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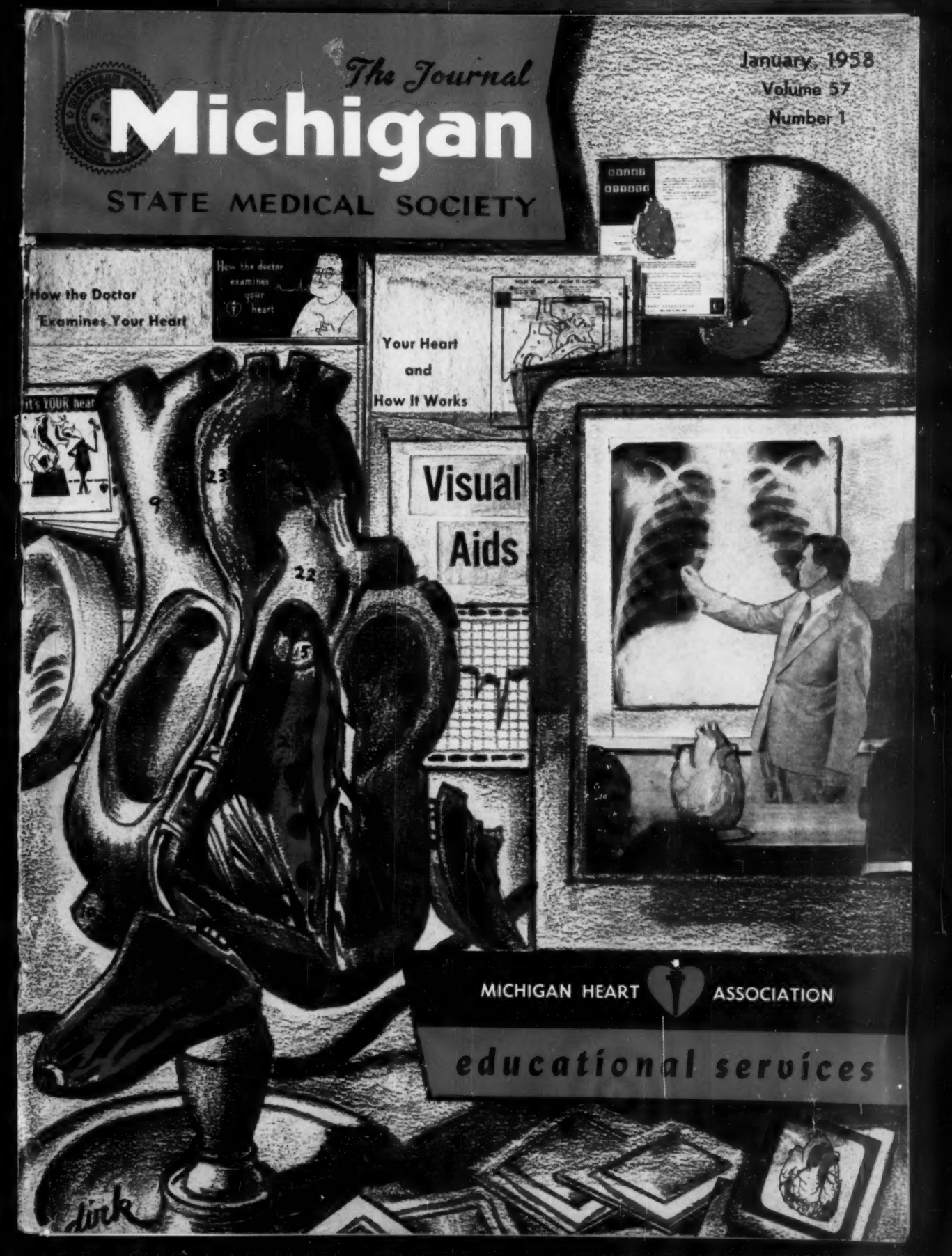

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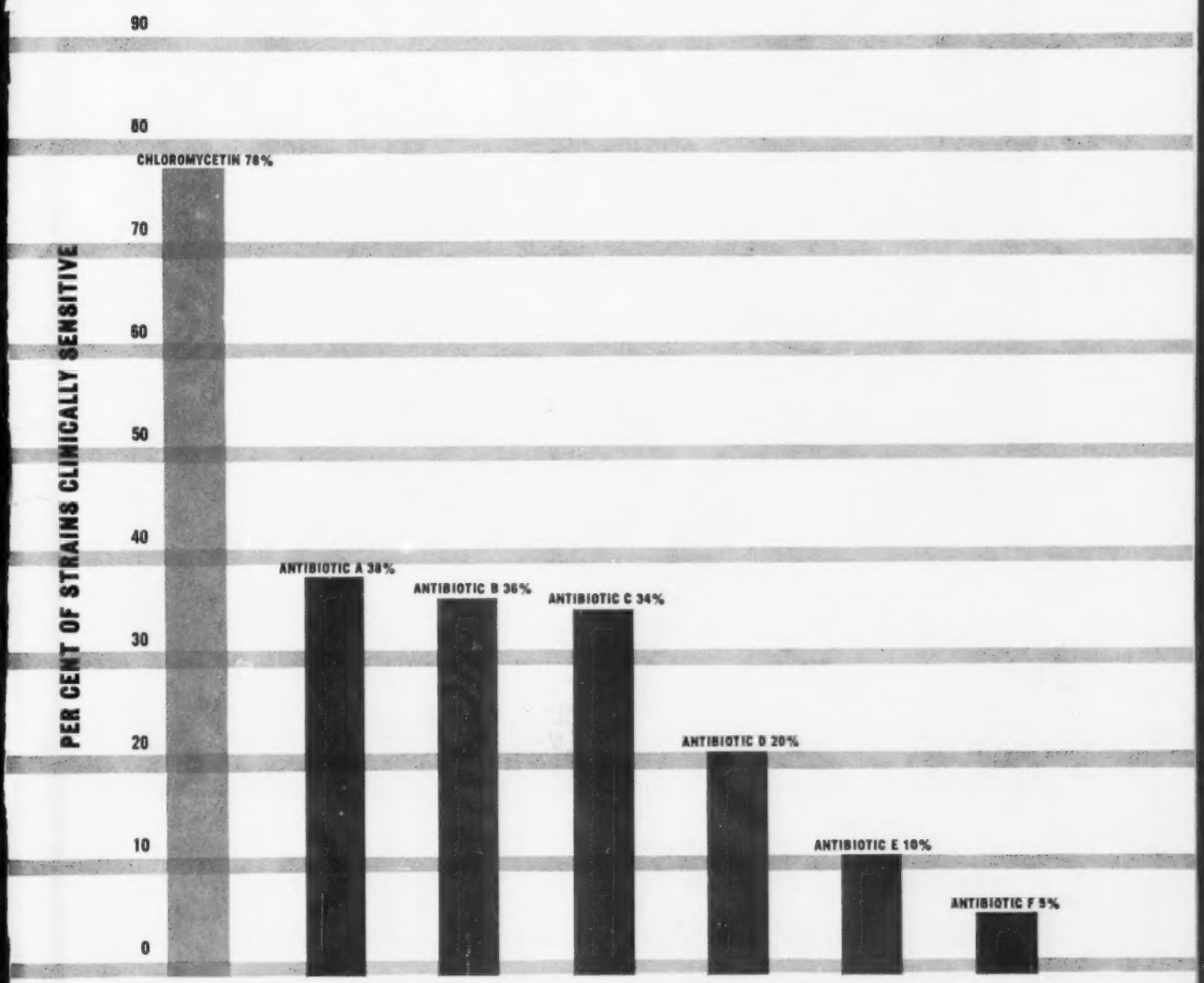
COMPARATIVE SENSITIVITY OF MIXED *PROTEUS* SPECIES TO CHLOROMYCETIN AND SIX OTHER WIDELY USED ANTIBIOTIC AGENTS*



*This graph is adapted from Waisbren and Strelitzer.[15] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

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Table of Contents

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(Continued on Page 8)

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(Continued from Page 6)

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(Continued on Page 9)

new

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CHLOROTHIAZIDE

an orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials

1 Gm. of 'DIURIL' orally is approximately equivalent to 1 cc. of mercurial I.M.[1]

FOR

initiation of diuresis – prolonged maintenance[2] of diuresis

balanced excretion of sodium and chloride

Even in the presence of severe renal, cardiac or hepatic damage–

Any indication for diuresis is an indication for 'DIURIL':

1. Congestive heart failure of all degrees of severity
2. Premenstrual syndrome (edema)
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4. Renal edema—nephrosis; nephritis
5. Cirrhosis with ascites
6. Drug-induced edema

   May be of value to relieve fluid retention complicating obesity

MERCK SHARP & DOHME

DIURIL is a trade-mark of Merck & Co., INC.

In hypertension

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CHLOROTHIAZIDE

Provides basic therapy to improve and simplify the management of hypertension

enhances markedly the effects of the antihypertensive agents

reduces dosages of other agents below the level of serious side effects

smoothes out blood pressure fluctuations[1,2]

'DIURIL', added to the regimen is often effective in controlling the blood pressure of even highly resistant cases of hypertension

For smooth, sustained antihypertensive effect, the majority of hypertensive patients can be controlled better when 'DIURIL' is combined with significantly reduced amounts of antihypertensive agents

Recommended dosage range: in hypertension—one 250 mg. tablet 'DIURIL' b.i.d. to one 500 mg. tablet 'DIURIL' t.i.d.

Supplied: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide), bottles of 100 and 1000.

References

1. Hollander, William, and Wilkins, Robert W.: Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension, Boston Medical Quarterly 8:69 (Sept.) 1957.

2. Freis, Edward D., and Wilson, Ilse M.: Potentiating Effect of Chlorothiazide (DIURIL) in Combination with Antihypertensive Agents, a Preliminary Report; Med. Annals of the District of Columbia 26:468 (Sept.) 1957.

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a major breakthrough in the management of two major medical problems

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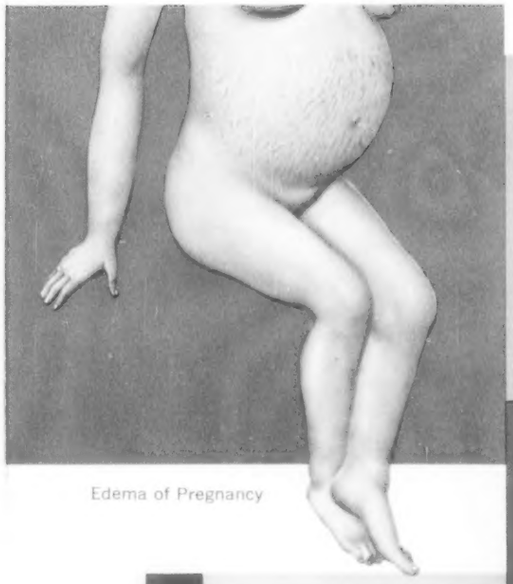
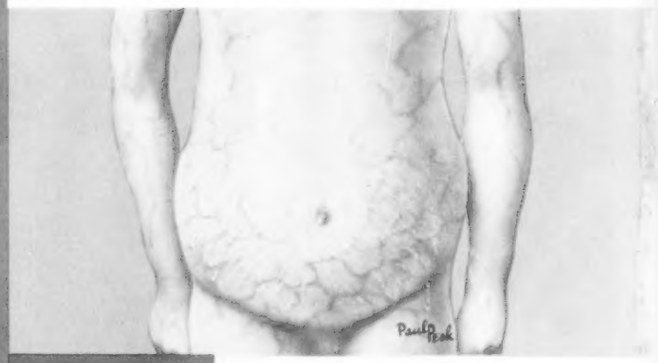
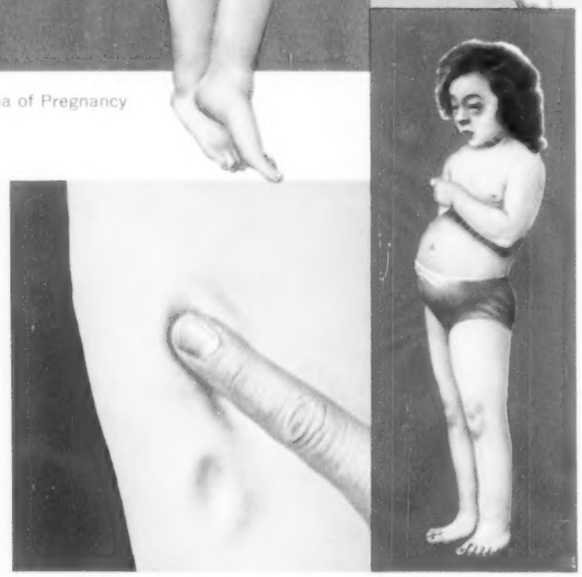


Edema of Pregnancy



Cirrhosis



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Nephrosis

Obesity with Fluid Retention

RECOMMENDED DOSAGE RANGE: in edema—one 500 mg. tablet 'DIURIL' to two 500 mg. tablets 'DIURIL' once or twice a day.

SUPPLIED: 250 mg. and 500 mg. scored tablets of 'DIURIL' (chlorothiazide), bottles of 100 and 1000.

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REFERENCES:

1. Moyer, J.H., Ford, R.V., and Spurr, C.L.: Pharmacodynamics of Chlorothiazide (Diuril), An Orally Effective Non-Mercurial Diuretic Agent, Proc. Soc. Exper. Biol. and Med. *95*:529 (July) 1957.

2. Ford, Ralph V., Handley, Carroll, Moyer, John H., and Spurr, Charles L.: Chlorothiazide, An Orally Effective Non-Mercurial Diuretic Agent, Med. Rec. and Ann. *51*:376 (April) 1957.

Committees of The Council, 1957-1958

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Isuprel HCl (10 mg. for adults, 5 mg. for children), the most potent bronchodilator known, makes up the outer coating. In a sudden attack, the patient puts the tablet under his tongue. Relief starts in 60 seconds. A unique feature is the "flavor-timer." As the Isuprel is absorbed a lemon flavor appears. When it disappears—about five minutes later — the patient swallows the tablet.

An unexcelled combination for prolonged bronchodilatation makes up the Isuprel-Franol core: benzylephedrine HCl (32 mg.), Luminal® (8 mg.) and theophylline (130 mg.). Swallowed, the tablet works for four hours or more.

Isuprel-Franol tablets are "... effective in controlling over 80% of patients with mild to moderate attacks of asthma."[1]

1. Fromer, J. L., and DeRisio, V. J.: *Lahey Clin. Bull.* 10:45, Oct.-Dec., 1956.

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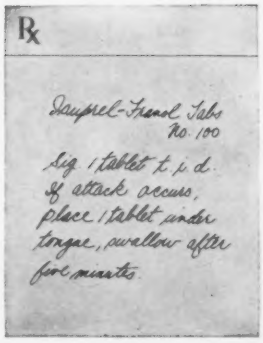
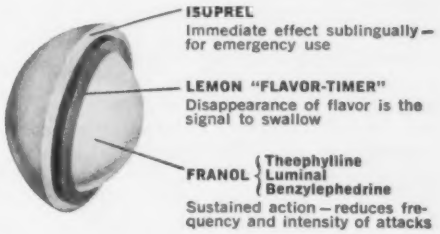


ISUPREL-FRANOL tablets (Isuprel HCl 10 mg.) for adults;
ISUPREL-FRANOL Mild tablets (Isuprel HCl 5 mg.) for children:

One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.
Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



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You and Your Business

LIVE SURGERY TO BE TELEVISED TO PUBLIC

One of the features of the 1958 Michigan Clinical Institute will be a public showing of "Blood Vessel Surgery" beamed from one of Detroit's hospitals to the public through the facilities of one or more television stations in the Motor City.

This color telecast will be made—live—the evening of Tuesday, March 18, 1958. Co-operating with the M.C.I. in this educational venture will be Smith, Kline and French Laboratories of Philadelphia.

Participants in the production will be D. Emerick Szilagyi, M.D., and Roger F. Smith, M.D., of Detroit, who will perform the surgery; the panel of experts to inform the viewing public on the intricacies of the operation will be Henry T. Bahnson, M.D., Baltimore, Md.; Prescott Jordon, M.D., Detroit; Eugene A. Osius, M.D., Detroit; and Marion deWeese, M.D., Ann Arbor.

Further information on the stations and the exact hour of the presentation will be sent to all members of the Michigan State Medical Society early in February.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of November 20, 1957

A total of ninety-seven items was presented and discussed at the November 20 meeting of the Executive Committee of The Council, held in Detroit, including:

- **Matters Referred to The Council by 1957 House of Delegates:** (1) Resolution re practice privileges in public hospitals—referred to the Legislative Committee. (2) Resolution re annual registration of doctors of medicine—referred to Liaison Committee with Michigan State Board of Registration in Medicine. (3) Resolution re pilot study of insurance reporting—authorization was given Saginaw County Medical Society to conduct a study of insurance reporting forms. (4) Six referrable items, having to do with pre-paid insurance plans—referred to Michigan Medical Service (Blue Shield).
- **Report of Delegates to AMA,** meeting of November 19, presented by Chairman Wm. A. Hyland, M.D., was discussed and approved.
- **Fee Schedule Committees:** A clarification of duties of several committees studying fee schedules was made by the Executive Committee including request to the Permanent Advisory Committee on Fees (Grover C. Penberthy, M.D., Detroit, Chairman) to proceed with development of a Relative Value Schedule of Services in conjunction with the Medical Care Insurance Committee (M. L. Lichter, M.D., Detroit, Chairman). The Committee on Uniform Fee Schedule for Governmental Agencies (T. H. Hunt, M.D., Detroit, Chairman) was requested to proceed with an early revision of that schedule.
- **Speaker K. H. Johnson, M.D.,** recommended certain changes in the MSMS House of Delegates' schedule, to modernize and make the session more efficient. Five meetings of the House would be held, beginning Sunday evening and running through Monday and Tuesday of the MSMS Annual Session week. The recommendations were approved, for trial in September, 1958.
- **Site Committee** (K. H. Johnson, M.D., Chairman) reported on an offer of property in the greater Lansing area; the Committee was authorized to proceed to purchase or obtain an option on this property.
- **President G. W. Slagle, M.D.,** Battle Creek, announced that he has appointed R. H. Trimby, M.D., of Lansing to the Child Welfare Committee.
- **The programs of the 1958 County Secretaries-Public Relations** Seminar and Editorial Workshop of February 1-2, were presented and approved.
- **Invitation to the AMA** to hold the 1960 Conference on Rural Health in Michigan was authorized.
- **R. M. Heavenrich, M.D.,** of Saginaw (Chairman of MSMS Child Welfare Committee), was authorized to attend U.S. Children's Bureau Conference on Adoptions, Washington, D. C., November 21-22.
- **Request of Section on Occupational Health** for change of name to "Section on Occupational Medicine" was approved.
- **G. B. Saltonstall, M.D.,** Charlevoix (MSMS President-Elect), was appointed as official MSMS representative to attend Conference on Medicare in Philadelphia, Decembr 6.
- **Michigan State Pharmaceutical Association** letter urging greater control of barbiturates—

(Continued on Page 16)

symptomatic relief . . . plus!

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TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND

ACHROCIDIN is a well-balanced, comprehensive formula for treating acute upper respiratory infections.

Debilitating symptoms of malaise, headache, pain, mucosal and nasal discharge are rapidly relieved.

Early, potent therapy is offered against disabling complications to which the patient may be highly vulnerable, particularly during febrile respiratory epidemics or when questionable middle ear, pulmonary, nephritic, or rheumatic signs are present.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets, or teaspoonfuls of syrup, three or four times daily.

tablets

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 24 tablets

syrup

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

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Significant Robins research discovery:

A NEW SKELETAL MUSCLE RELAXANT

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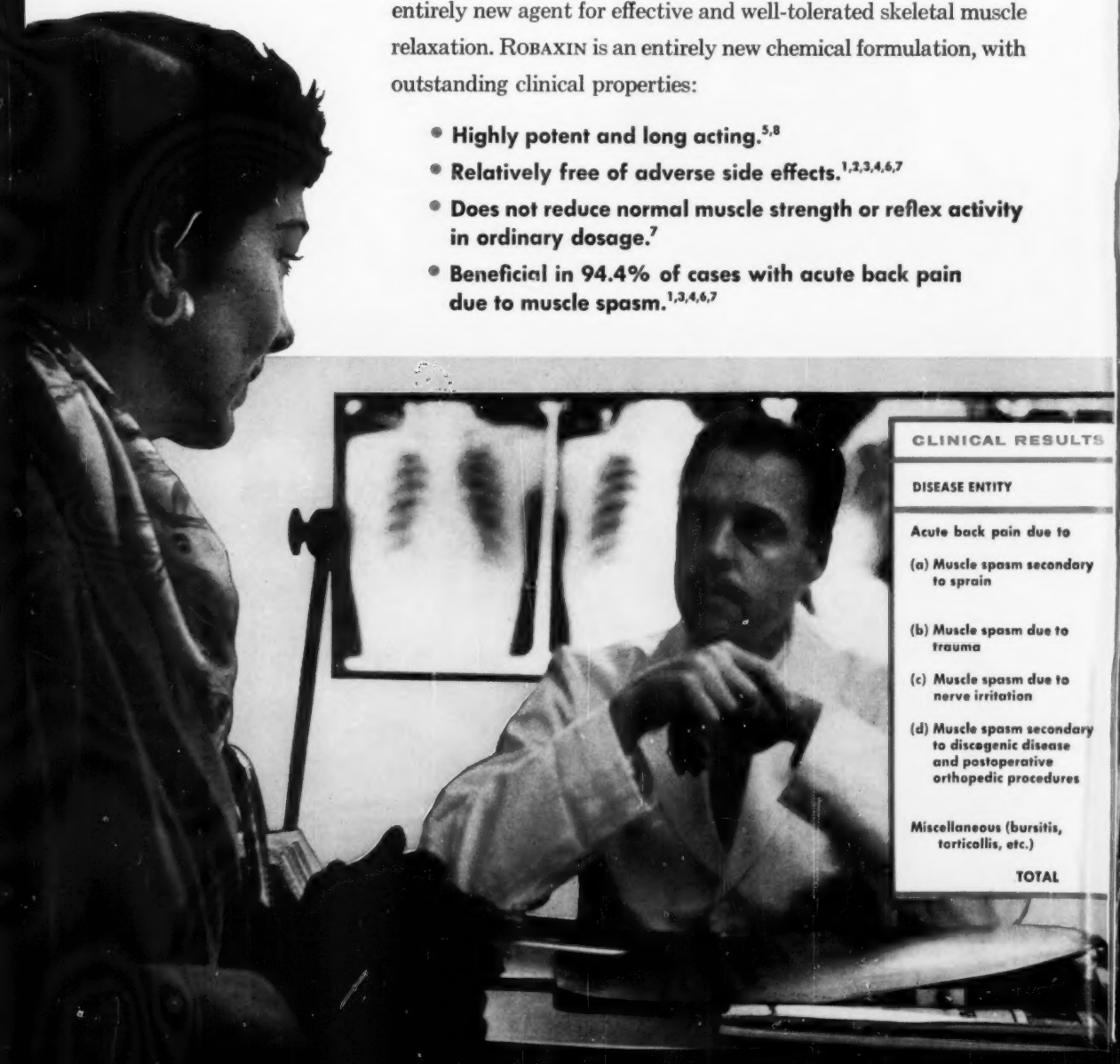
ROBAXIN – synthesized in the Robins Research Laboratories, and intensively studied for five years – introduces to the physician an entirely new agent for effective and well-tolerated skeletal muscle relaxation. ROBAXIN is an entirely new chemical formulation, with outstanding clinical properties:

- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RESULTS	
DISEASE ENTITY	
Acute back pain due to	
(a) Muscle spasm secondary to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm secondary to discogenic disease and postoperative orthopedic procedures	
Miscellaneous (bursitis, torticollis, etc.)	
TOTAL	

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(Methocarbamol Robins, U.S. Pat. No. 2770649)

Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

WITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

NO. OF CASES	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
18	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
13	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
5	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
30	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
6	3-60 days	4-8 Gm.	6	0	0	0	None, 6
72			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

Supply – Robaxin Tablets, 0.5 Gm., in bottles of 50.

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Ethical Pharmaceuticals of Merit since 1878

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 12)

not to be prescribed over the telephone—was discussed. The Executive Committee of The Council felt that MSMS members should abide by the present law covering this matter.

- **Committee Reports:** (1) Committee on Awards, meeting of November 20; (2) Medical Advisory Committee to Michigan Hospital Service, October 17; (3) Committee Organization, October 23; (4) Geriatrics Committee, October 29; and (6) Michigan Clinical Institute Program Committee, November 11.

- **Matters of mutual interest** were discussed with Michigan Health Commissioner A. E. Heustis, M.D., including: (1) Radiation Standards; (2) Incidence of poliomyelitis; (3) Michigan Public Health Study Commission and its report; and (5) Explosion at Pontiac Paint and Varnish Company.

- **Editor Wilfrid Haughey, M.D.,** Battle Creek, presented a report on two meetings: (a) AMA Sub-Committee on Indigent Care, Chicago, October 20-21; and (b) State Medical Journal Advertising Bureau Conference, Chicago, October 28-29.

- **The Executive Committee of The Council** approved placing JMSMS on microfilm so that it be made available to libraries et al.

- **Council Chairman D. Bruce Wiley, M.D.,** Utica, announced the following appointments: Committee to Review Problems of Medical-Professional Liability: C. E. Umphrey, M.D., Detroit, Chairman, assisted by Charles H. Clifford, M.D., Detroit, and Lester P. Dodd, LL.B., Detroit. E. P. Vary, M.D., Flint, as Chairman and A. H. Kretchmar, M.D., Flint, as member of the Hospital Relations Committee. Bernard Goldman, M.D., Mt. Clemens, to the Committee on Uniform Fee Schedule for Governmental Agencies. F. C. Ryan, M.D., Kalamazoo, to Medical Care Insurance Committee; B. M. Harris, M.D., Ypsilanti, as Chairman and Arch Walls, M.D., as member of Healing Arts Study Committee.

- **St. Clair County Medical Society's** "standard insurance form," to be used by members of that Society, was given approval.

- **Public Relation Counsel's report** included: (a) MSMS Opinion Study; (b) HR 6452 and other legislation; (c) Physician's Award for Vocational Rehabilitation; (d) Premiere of "Something Called Epilepsy"; and (e) Emergency Medical Care.

PREVIEW OF THE 1958 MLA MEETING

The fifty-seventh annual meeting of the Medical Library Association will be held in Rochester, Minnesota, from June 2 through June 6, 1958, with headquarters at the Hotel Kahler. The theme of the Rochester meeting will be "Advances in Medical Library Practice." Mr. Thomas E. Keys, Librarian of the Mayo Clinic, is convention chairman, and letters of inquiry should be addressed to him.

A pre-convention activity is being planned for Saturday, May 31. A series of refresher courses embracing many fields of medical library work will be given. Classes will be made up from the following subjects: Administration, Acquisitions, Classification, Cataloging, Non-book materials, Photoduplication, Public Relations, Reference Work, Rare Books, History of Medicine, Bibliographic Services, Periodicals, Binding, Library Architecture, Equipment, and Medical Terminology.

It will be possible for each participant to take four courses during the day, two in the morning and two in the afternoon. Each session will be one and one half hours in length, the hour for a prepared lecture and a half hour for a discussion period.

Among the highlights of the regular program will be a panel discussion on what the medical specialists expect from the Medical Library. Speakers will be from the Mayo Clinic staff. A one-day trip is being planned to Minneapolis and Saint Paul with visits to the University of Minnesota, The James J. Hill Reference Library, and the Ramsey County Medical Library.

After a day in the Twin Cities, the remainder of the program will be held in Rochester. There will be a Symposium on the Medical Center Library, and a session on American Medical History and Medical Librarianship.

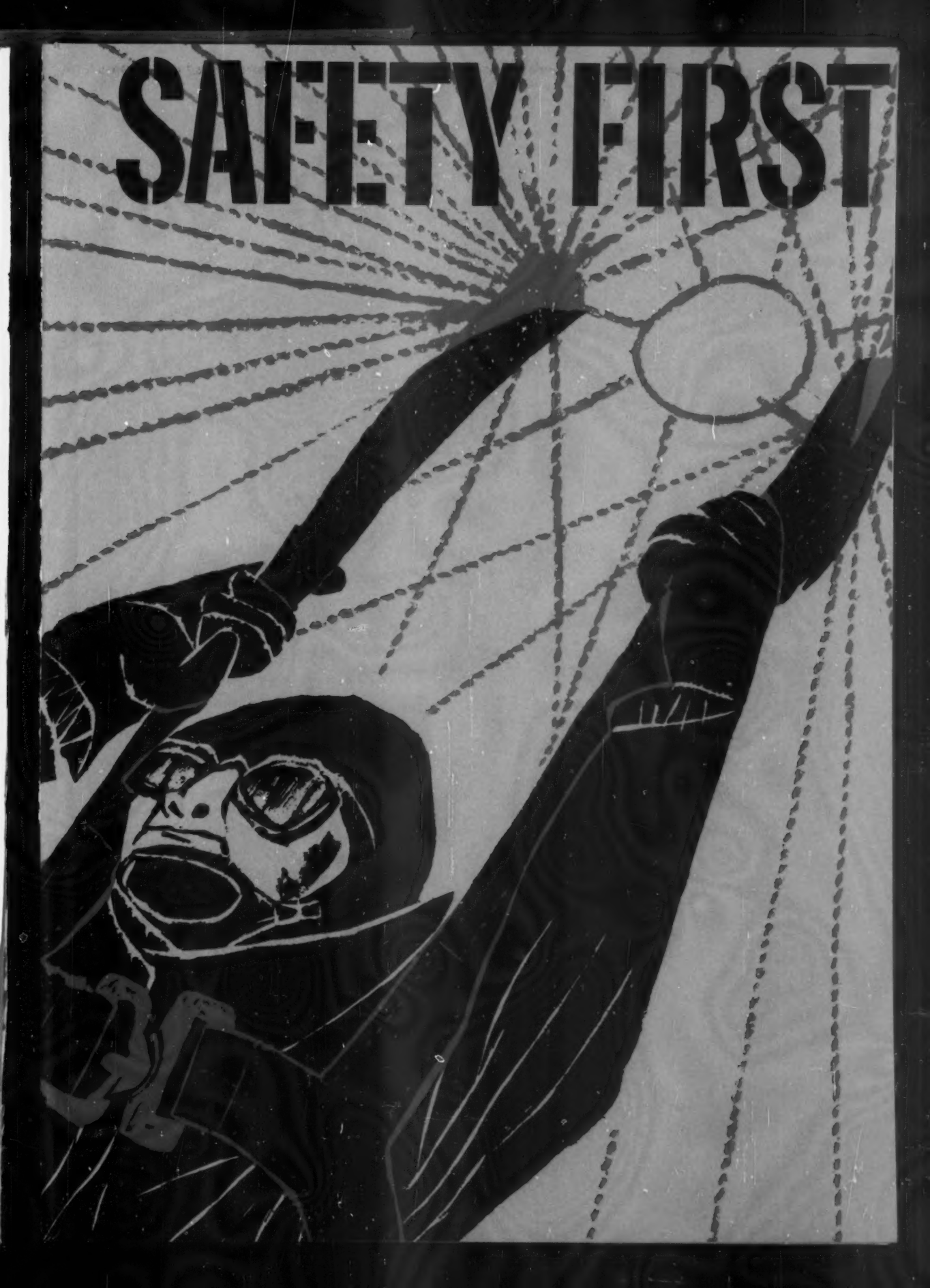
Arrangements are being made for preconvention and postconvention tours for those who may wish to explore some of the natural beauty of Minnesota. All medical librarians are cordially invited to attend.

AMERICAN NURSES ASSOCIATION ROLL CALL

The Michigan State Nurses Association will join all other state nurses associations in the 1958 "ANA Roll Call," a nationwide membership promotion program to be launched on January 15, and to continue through January 31.

Aim of the Roll Call, the first such event to be sponsored by the American Nurses Association, is to enlist through personal contact the interest and support of every professional nurse in order to strengthen the nursing profession, the professional membership organization and the individual member. During the two-week period of the Roll Call,

(Continued on Page 18)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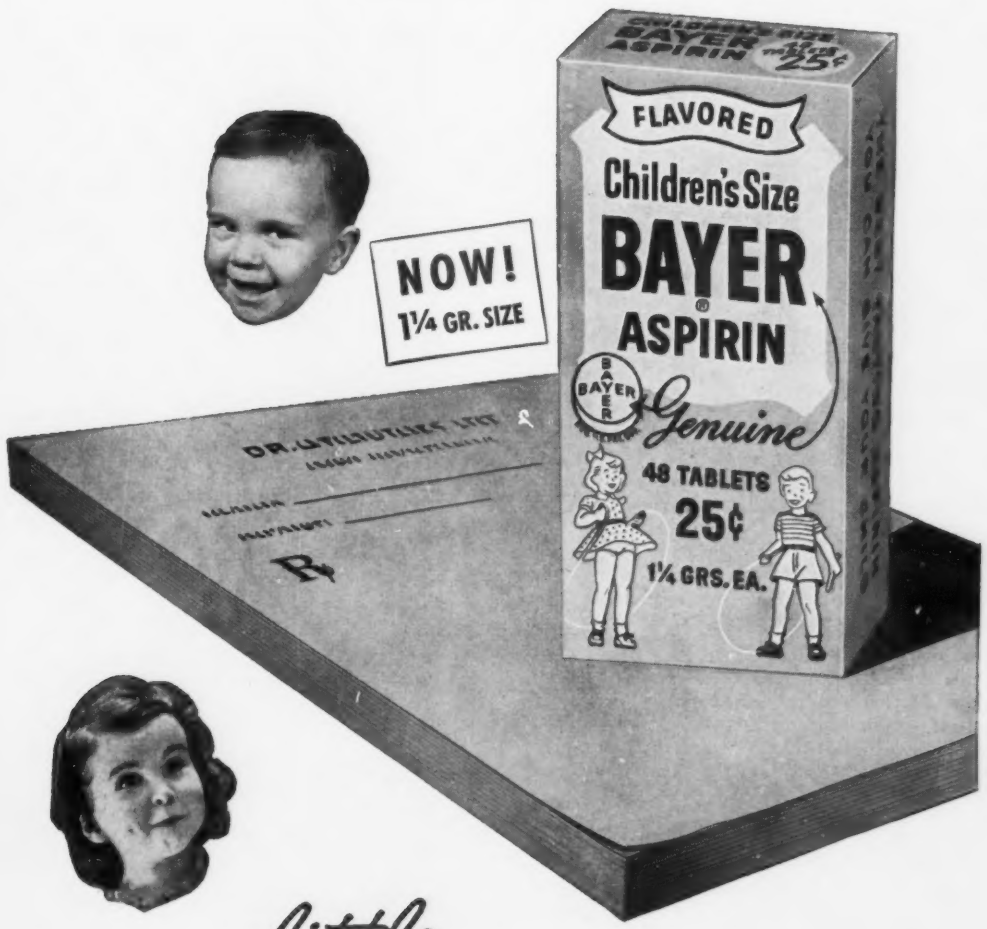

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AMERICAN NURSES ASSOCIATION ROLL CALL

(Continued from Page 16)

members of MSNA will try to contact all prospective members to tell them about the association.

The basic plan is to have all professional nurses, members or not, become better informed as to the need and purpose of a professional nurses association; to know its various functions; to learn how the local district can become a dynamic force in the community; to learn the many ways through which all nurses can assist in the promotion of nursing and the improvement of the status of the professional nurse; to fully understand why professional nurses need to be members and actively participate in the work of the association; to realize it is not for personal gain only, but for a democratic, organized channel through which the professional nurse may contribute of her knowledge, thoughts, ideas, skills and efforts to the ultimate goal—that of promoting professional nursing to the end that better nursing care is given to the public whom we serve.

The office nurses have formed their own section within Michigan State Nurses Association and a national section will be formed early in 1958. All office nurses are encouraged to join MSNA and be identified with the official professional organization. Through their section the office nurses will be able to shape the future of their practice, improve the care given to patients, exchange ideas and experiences about their work, learn better ways of working with allied professional personnel, and improve their economic and general welfare.

A successful Roll Call will take the co-ordinated efforts of many nurses and MSNA is anticipating an appreciable increase in membership in 1958. Knowing the value of a professional association, the members of the Michigan State Medical Society are being asked to lend their support to the MSNA Roll Call.

COUNTY SOCIETY ACTIVITY

Calhoun County

The Calhoun County Medical Society and the ladies held a formal reception and dinner dance in honor of the retiring president Lee Shipp, M.D., December 6, 1957. This was also made the occasion of honors to George W. Slagle, M.D., and Mrs. Slagle in recognition of his presidency of the Michigan State Medical Society.

Genesee County

Quite a number of county medical societies have the habit of making their annual meeting a dinner and reception in honor of the immediate past president. On November 26, 1957, the Genesee County Medical Society honored its immediate past president, Otto J. Preston, M.D., and this year added to the occasion by including a list of twenty past presidents serving prior to the year 1953-1954. Through its committee on alcoholism, the Genesee Society has issued a very attractive eight-page pamphlet with cover on "A Happy Solution to the Problem of Alcoholism."

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"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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AMA Washington Letter

THE MONTH IN WASHINGTON

Eleven years ago, in passing the National Employment Act of 1946, Congress provided for two organizations whose sole function is to promote maximum employment, maximum production and maximum purchasing power. One is Congress' own Joint Economic Committee; the other, the President's Council of Economic Advisers.

The President's Council constantly studies all forces—social as well as financial—that affect employment and production, and before each January 20 makes its report to the President, who in turn utilizes that in drafting his annual economic report to Congress.

At the same time the Congressional Joint Economic Committee is making its own separate studies, holding hearings and preparing a background of information against which to judge the President's economic recommendations when they come before it. The Congressional committee, however, is wholly advisory; it does not itself draft legislation but makes public its annual report before each March.

Although this committee is denied legislating power, its influence often directs the course of legislation. For example, a strong, one-page report from this committee is credited with keeping Congress in session after start of the Korean war and thus preventing a scheduled decrease in taxes.

When it calls in witnesses, the Joint Committee attempts to obtain a broad cross-section of opinion —the liberal along with the conservative. For this reason, recent hearings under sponsorship of the Joint Committee attracted more than casual interest. They brought together conflicting general philosophies and controversial specific issues. In the health-welfare fields, the following were some of the views:

The question of hospitalization for the retired aged through the social security mechanism was debated pro and con by the panelists. Two views:

Prof. Wilbur Cohen, University of Michigan—The former Social Security official maintains that the system can stand the drain of hospitalization for the aged. It could be done for one half of 1 per cent of taxable income, he argued, and he would raise the latter to the first $6,600 of income instead of the present $4,200.

W. Glenn Campbell, American Enterprise Association—Congress should give the medical profession and the insurance industry a chance to work out this problem through traditional methods rather than institute a costly compulsory system with all its attendant damage to the effective practice of medicine.

Secretary Folsom of HEW—The burdens of disease, disability, ignorance and insecurity cannot be escaped by under-investment in health, education and welfare. Such an under-investment would have a costly effect on private charities, budgets of governments, efficiency of industry and the purchasing power of consumers.

Prof. Clarence D. Long, Johns Hopkins University—An expansion of social welfare programs will have a very great stimulating effect on the economy, provided we play down those programs that involve mere charity and emphasize those that help people to help themselves.

On the day of the hearing on health, education and welfare, the panelists agreed that no crash programs in education were called for despite the scientific manpower shortages. Other comments on education:

Professor Paul J. Strayer, Princeton University—Either federal aid will be forthcoming on terms that can be acceptable to the states or we will suffer a general deterioration in the quality of education.

President Howard R. Bowen, Grinnell College—Federal aid should not be granted directly to colleges and universities but through intermediary non-profit corporations controlled by boards of trustees made up of distinguished citizens.

NOTES: A possible indication of legislation in 1958 comes from a December tour of southern medical schools by members of the House Interstate and Foreign Commerce Committee's health subcommittee. Among other things, they were concerned with the schools' need for more laboratories and classrooms.

The Department of Health, Education and Welfare has started a 12-year study on the activities of a group of 3,000 newly retired men and women.

Community-wide chest x-ray campaigns to detect tuberculosis, long a popular public health device, now are in disfavor with U. S. Public Health Service. PHS recommends instead that tuberculin skin tests be used generally with chest x-rays reserved for selective groups likely to have high incidence of the disease.

Between July 1 and mid-December, almost half the population of the country had been taken ill with an upper respiratory condition, including Asian influenza.

In its first year of operation, Medicare spent $43 million, with $22 million going to civilian physicians and $21 million to civilian hospitals; administrative costs ran about 3 per cent. Some claims are still pending.

AMA News Notes

AMA-AHA JOINT COMMITTEE STUDIES MEDICOLEGAL PROBLEMS

A concerted educational program on medical professional liability is being formulated by a joint committee of the American Medical Association and the American Hospital Association. Among other things, the liaison committee plans to study current medicolegal advisory set-ups in a number of states, the liability of charitable and governmental hospitals, and ways of promoting postgraduate education in the professional liability field. Progress reports will be submitted to the boards of trustees of the two associations, and physicians and hospital personnel will be kept informed on all action taken through the organizations' official publications.

Representatives appointed from AMA include: Drs. Joseph F. Sadusk, Jr., Oakland, Calif., chairman; H. Close Hesseltine, Chicago, and William M. Nebeker, Salt Lake City. AHA representatives are: Ray E. Brown, Chicago; Dr. August H. Groeschel, New York, and James E. Ludlam, Los Angeles.

MD'S TO SEE NEW MEDICOLEGAL FILM IN JUNE

The AMA Law Department announces that "traumatic neurosis" will be the subject of the third film in the series of six medicolegal films to be produced in cooperation with the Wm. S. Merrill Company of Cincinnati. The film will delve into some of the problems that face psychiatrists and neurologists in identifying patients' psychoses resulting from various traumatic experiences. Physicians will have an opportunity to see the premiere showing of this film at the AMA's Annual Meeting in June in San Francisco.

Previous motion pictures in the series include "The Medical Witness" and "The Doctor Defendant." Other films in the series will deal with in-hospital medical professional liability problems and forensic pathology.

RURAL HEALTH CONFERENCE SCHEDULED

Changing patterns in nutrition, health costs, medical care, dental health and safety will serve as the focal point for discussion at the thirteenth national Conference on Rural Health to be held March 6-8, 1958, at the Hotel Heidelberg, Jackson, Mississippi. The conference is sponsored by the AMA's Council on Rural Health in co-operation with southern state medical associations and farm, educational and allied organizations. Following the theme—"As the World Turns"—the conference will open Thursday morning, March 6, with greetings by the governor of Mississippi, the mayor of Jackson, the president of the Mississippi State Medical Association, a member of AMA's Board of Trustees and the chairman of the Council.

Highlights include: *Thursday afternoon*—panel on nutrition and a skit depicting a family's visit to the dentist. *Thursday evening*—presentation on a visit to the doctor's office with emphasis on the physical examination. *Friday morning*—panel on safety and a discussion of what the patient expects from his doctor and the doctor of his patient. *Friday afternoon*—panel on new developments in health insurance plans and a report on Mississippi's physician training and placement service. *Friday evening*—annual banquet.

Saturday morning—five presentations on outstanding achievements in rural communities: (1) health improvement association in rural Illinois; (2) Oklahoma's visiting nurses service; (3) a 4-H Club safety lifting program; (4) 4-H Club work in Nebraska, and (5) Ohio's preceptorship program. Also a summary and inspirational message will be given by Mrs. Charles W. Sewell of Otterbein, Ind., member-at-large of the advisory committee to the Council.

TWO NEW AMA EXHIBITS

Reducing and accidental poisoning of children are the themes of two new exhibits the American Medical Association is offering to medical societies early in 1958. (1) "You Can Reduce" stresses the importance of using will power in the selection of foods. The exhibit illustrates the basic foods that should be eaten every day, those to "fill up" on and those to "cut down" on. Three dimensional models depict the calorie content of certain basic foods. (2) "Poisoning of Children in the Home" pinpoints eight leading offenders, such as aspirin, kerosene, old medicines and household chemicals. A display of products on a revolving tree-like arrangement also is included in this portable exhibit. Medical society bookings may be arranged through the Bureau of Exhibits after January 1.

SECOND LEGAL CONFERENCE PLANNED

Legal problems currently facing individual physicians and organized medicine will be the primary discussion topics at the second meeting of state and county medical society executive secretaries and attorneys May 9-10 at the Drake Hotel, Chicago. Before the final agenda can be set up, the AMA Law Department hopes that medical societies will send in their suggestions on specific legal subjects that would be of the most interest to them. The first such meeting—also sponsored by the Law Department—was held in April, 1956.

RADIO-TV REPORT AVAILABLE FROM AMA

Medical societies interested in developing worthwhile local radio and television programs may secure copies of the summary of the recent radio-TV conference sponsored by the AMA and the National Association of Radio and Television Broadcasters from the AMA's Public Relations Department. The report contains basic information and helpful hints on using local radio ad television in the health field. Representatives of state and county medical societies, allied health and welfare organizations and radio and television stations attended the two-day Chicago meeting.

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Caffeine	30 mg.
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PR REPORT

HOUSE AND SENATE SHIFT INTO HIGH

With the February 12 cut-off date for introduction of bills looming near, the legislative tempo is picking up. Committees are working hard to clear their dockets. Non-critical bills are being shelved until next year as lawmakers strive to hold to their scheduled adjournment date of April 11.

CAPITOL NOTE: Former Michigan Attorney General Thomas M. Kavanagh assumed his position on the Supreme Court in Lansing swearing-in ceremonies the first of January. He was elected to that body in the 1957 spring election. Universersity of Michigan Regent Paul L. Adams (Sault Ste. Marie) succeeded Kavanagh as Attorney General by gubernatorial appointment last December.

PONTIAC HOSPITAL OPENS POISON CONTROL CENTER

St. Joseph Mercy Hospital in Pontiac has become the fourth hospital in the state and the twenty-third in the nation to establish a Poison Control Center. Robert J. Mason, M.D., assistant chief of pediatrics at the hospital, instituted the center which will contain a card index on the approximately 10,000 products found in most homes. The toxic and non-toxic ingredients of each product as well as antidotes will be typed on cards enabling the doctors to give prompt advice to people who make emergency phone calls. By referring to the cards, the doctors will also be able to determine whether the patient should be taken to the hospital.

COUNTY SOCIETY BULLETIN EDITORS ATTEND WORKSHOP

Practicing medicine and serving as editor of a county society bulletin are both fulltime jobs. The problem for the physician editor is how to put out the best Bulletin with the least expenditure of time.

In late January, an Editor's Workshop sponsored by MSMS was arranged to meet this problem head-on and offer individual and group help to representatives of the fifteen county medical societies who publish monthly journals.

All aspects of producing a specialized periodical were discussed by leaders in special fields. News writing and reader appeal were discussed by Jack Pickering, Science Editor of the *Detroit Times*, who led off the meeting as luncheon speaker.

Other topics covered in round-table session were: "How to Get the Best Out of Your Printer;" "Building Advertising Income"; "Format and Design—the Key to Readership."

The Editor's Workshop is the first attempt to bring editors and the press together on a statewide basis. Its success could mark the beginning of similar workshops in this specialized field of medical public relations on local levels.

LOCAL PR NEWS

(Gathered from the statewide press)

Bay City druggists and medics gathered at a joint dinner meeting in mid-November, where J. D. Miller, M.D., of Grand Rapids, served as panelist in his capacity as Chairman of the MSMS Liaison Committee with the Michigan State Pharmaceutical Association.

* * *

The Saginaw County Medical Assistants Society highlighted its dinner program of November 12, with a surprise tribute to J. E. Manning, M.D., for his work in furthering the activities of the assistants group during Doctor Manning's term as president of the local medical society.

* * *

Lapeer doctors of medicine offered to test all of their patients for diabetes without charge during Diabetes Week, November 17-23. The drive was announced by T. K. Buchanan, M.D., president of the Lapeer County Medical Society.

* * *

Doctors of the Upper Peninsula met with hospital administrators and legislators in early November and discussed the financial problems of hospitals. Highlights of the agenda were the State's practice of paying fees which are less than the actual cost of care of the crippled children which it sends to hospitals, and the problem of the hospitals' failure to collect many large bills for accident cases.

* * *

George W. Slagle, M.D., MSMS President, was guest speaker at the November meeting of the Barry County Medical Society. Dr. Slagle discussed the aims and purposes of organized medicine and the inter-relationships of the state and local groups.

* * *

Doctors and lawyers held their second annual joint meeting in Muskegon in mid-November. Program panelists included Grover C. Penberthy, M.D., and Lester P. Dodd, MSMS Legal Counsel. Interprofessional relationships of doctors and lawyers, was the evening's topic for discussion.

* * *

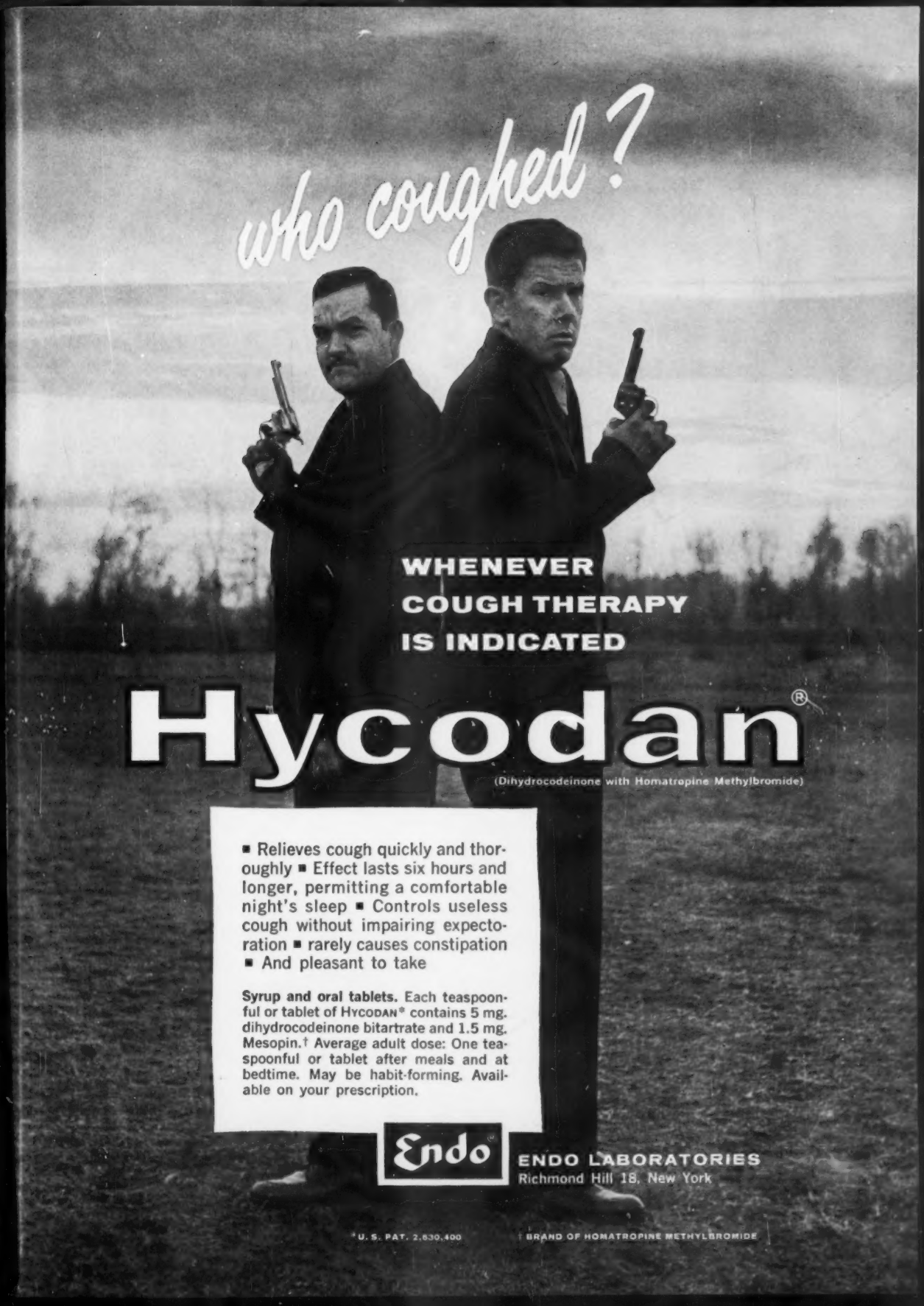
Cyrus B. Gardner, M.D., of Lansing, was presented a citation for outstanding service to the community and the Ingham County Medical Society, November 19, at the Society's monthly meeting. Doctor Gardner has practiced thirty-six years in his community and is a former president of the State Board of Registration in Medicine.

* * *

A formal banquet honoring Thomas J. Bass, M.D., of Ypsilanti, was given by members of St. John Baptist Church on November 13. Doctor Bass is assistant chief of medical service at Beyer Memorial Hospital.

* * *

Saginaw physicians, dentists and druggists held their annual stag dinner recently and drug stores announced they would close for the occasion. Emergency telephone numbers for each were posted and advertised. Doctors' calls were handled through their business bureau.



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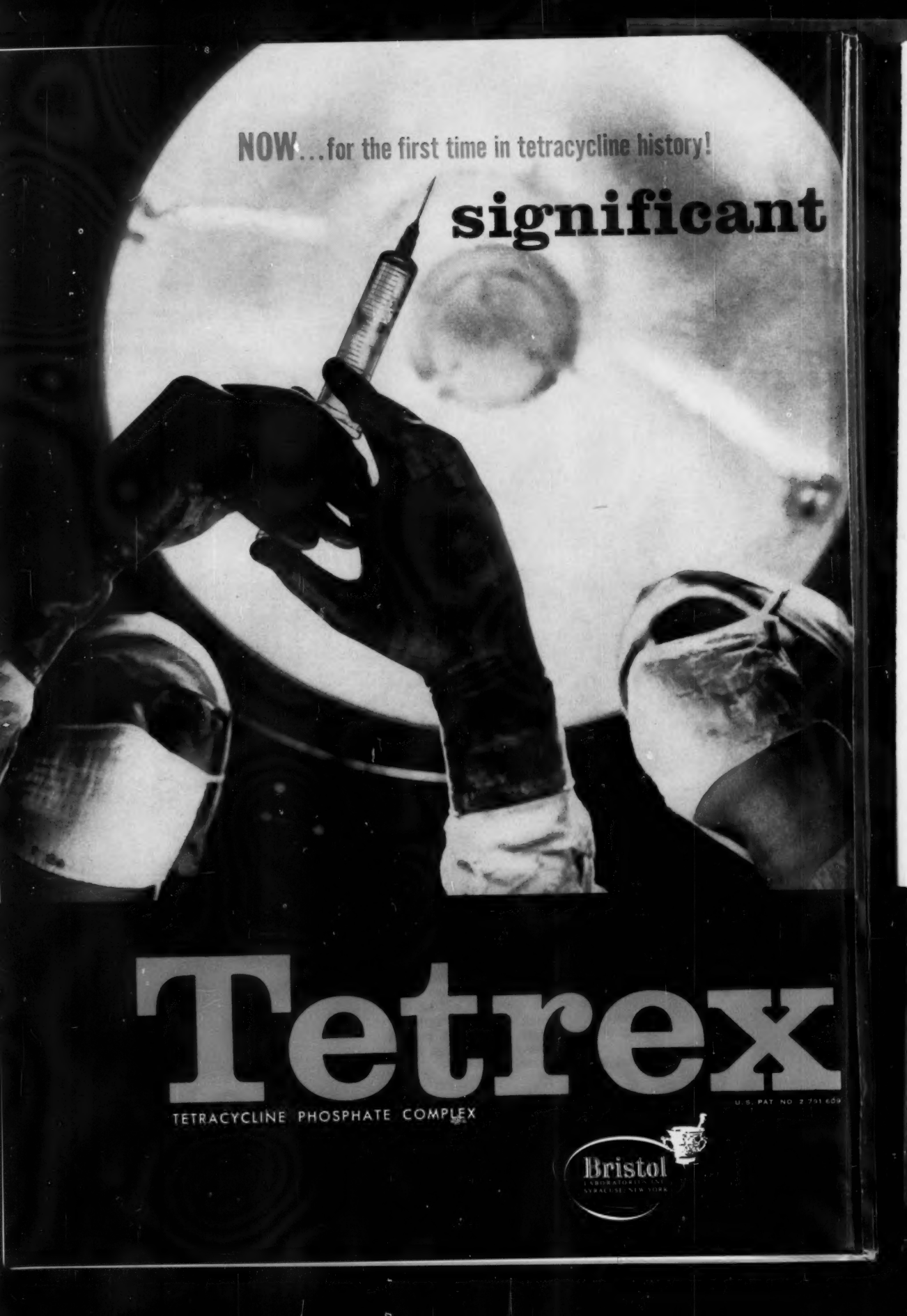
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SUPPLY: Single-dose vials containing TETREX – tetracycline phosphate complex – each equivalent to 250 mg. tetracycline HCl activity. Also available in 100-mg. single-dose vials.

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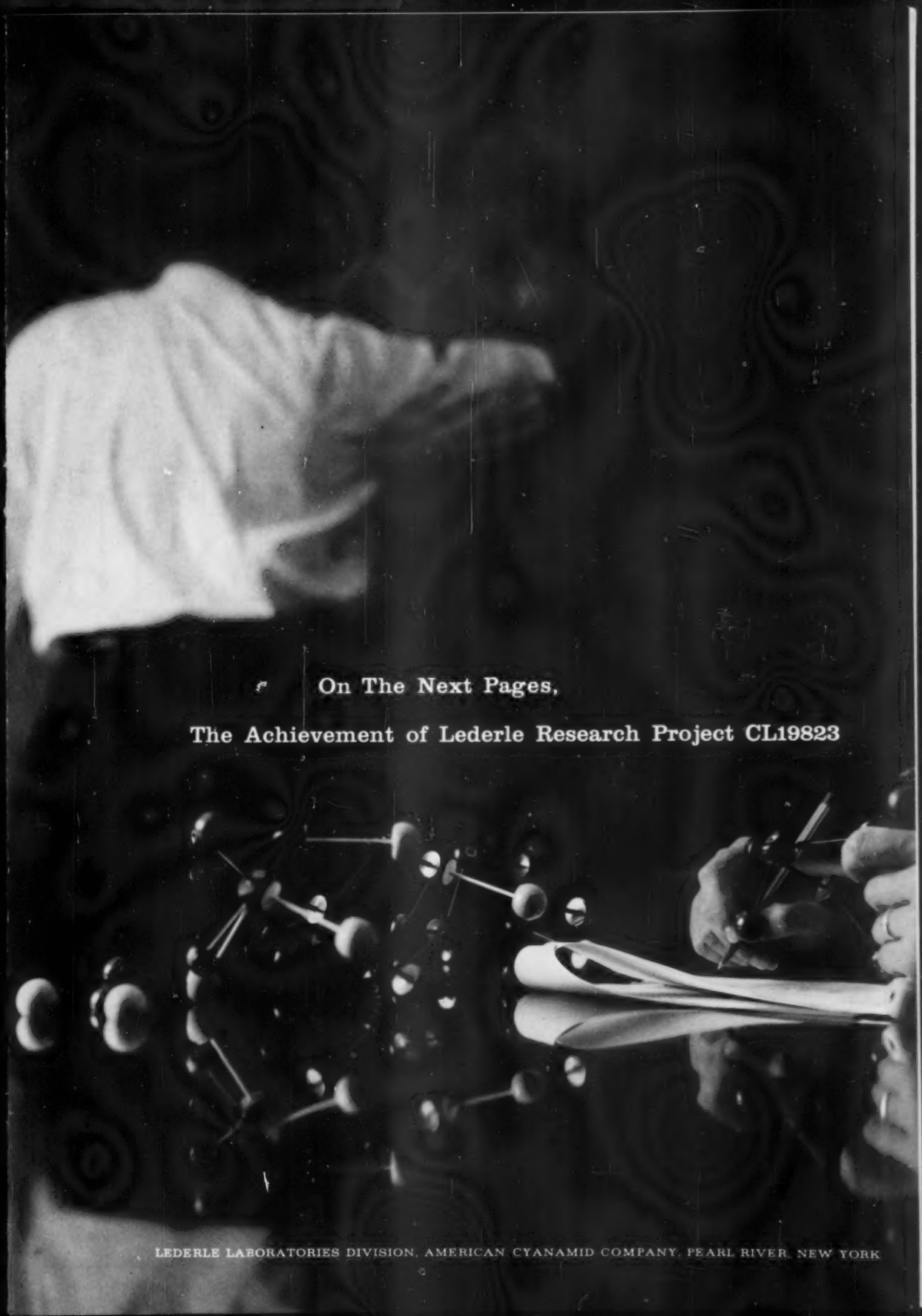

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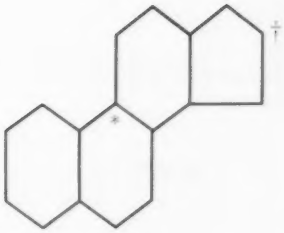

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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Lower incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

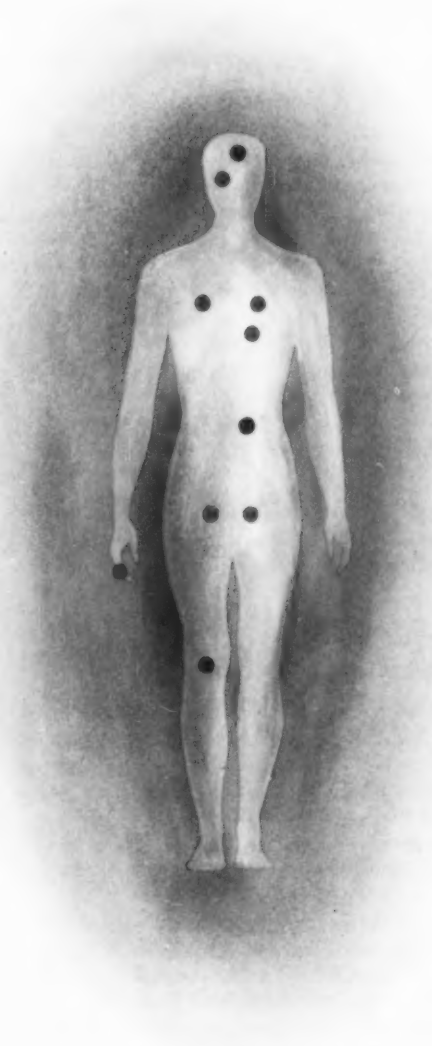
Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

◊ It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are below compared to the reported incidence of those from prednisone and prednisolone.

Peptic Ulcer

The most recent study available on the incidence of peptic ulceration in patients with rheumatoid arthritis on long-term prednisone therapy reported 12 ulcers in 49 cases (24 per cent).[1] Lowest incidence of 6.5 per cent has been recorded in a group of patients on this drug for six to nine months.[2] Four of six ulcers, in another series of 39 patients on prednisone,[3] appeared in less than three months of therapy.

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The incidence of compressed fractures of vertebrae—and to a lesser extent in other bones—is high in patients on prolonged therapy with all previous corticosteroids.[4] One group of 49 patients[1] on long-term prednisone treatment experienced nine vertebral fractures (18 per cent); another series of 39 developed eight fractures (20 per cent),[3] four to 15 months after the beginning of steroid administration.

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[5]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[4] and toxic syndromes producing even convulsions and death.[6]

Since the onset of these complications is not directly related to duration of steroid administration,[7] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension-Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[8] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[5,9]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[10,11] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[5] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[12] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[8] and in inflammatory and allergic skin diseases (33-50 per cent).[13,14]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in a lower incidence of the major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Reviews of ataraxic therapy commonly divide the available tranquilizers into three main categories: the rauwolfia derivatives; the phenothiazine compounds; and a smaller group of agents which are lumped together for the sake of convenience rather than because of any common characteristic.

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3. ATARAX is, perhaps, the safest ataraxic known. It is outstandingly well tolerated. Every clinical report confirms this fact.* After more than 150 million doses, there has not been a single report of toxicity, blood dyscrasia, parkinsonian effect, liver damage, or habituation.

4. ATARAX is unusually flexible. This lack of toxicity makes it possible to adjust ATARAX dosage to virtually any patient need. In the lowest range, children respond well to 10 mg. or one teaspoonful of syrup t.i.d., while anxious adults usually are treated with 25 mg. q.i.d. Yet, if needed, the dosage can safely be raised: in more severe disturbances, dosages up to 1,000 mg. daily have been administered without adverse reactions.

In reviewing your own experience with tranquilizers, remember that ATARAX is in a class by itself; that you cannot judge it by your results with any other drug. To get to know ATARAX at first hand, prescribe it for the next four weeks whenever a tranquilizer is indicated. See for yourself how it compares.

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100 mg. tablets—one tablet t.i.d.

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Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
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Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

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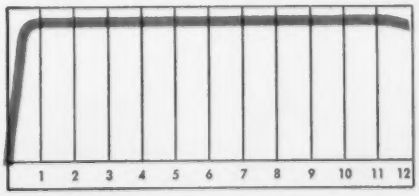

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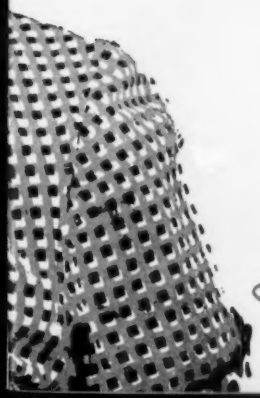

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VOLUME 57 JANUARY, 1958 NUMBER 1

Induced Cardiac Arrest as an Aid in Open Heart Operations

By Conrad R. Lam, M.D., Thomas Gahagan, M.D., Charles Sergeant, M.D., and Edward Green, M.D.
Detroit, Michigan

PROGRESS in cardiac surgery has been rapid and dramatic since the successful ligation of the ductus arteriosus by Robert Gross in 1938. Actually, the first "heart operations," which were for patent ductus arteriosus, coarctation of the aorta and the tetralogy of Fallot, were not carried out on the heart itself but involved the great vessels outside the pericardium. The first practical intracardiac operation was the transventricular pulmonary valvotomy devised by the London surgeon, Brock. Then came mitral commissurotomy, aortic commissurotomy and closed methods of the repair of interatrial septal defects. In these operations, the surgeon could feel, but not see, what he was doing.

The use of general body hypothermia made possible at least two intracardiac operations under direct vision, namely, pulmonary valvotomy and the closure of simple interatrial septal defects. The management of defects requiring more than 5 minutes of cessation of the circulation was not possible until a satisfactory method of extracorporeal oxygenation of blood was available. Lillehei and the group at the University of Minnesota Hospitals were able to repair ventricular septal defects with the use of an anesthetized human being as the "extra corporeal lung."[1] Shortly afterward, they developed a practical oxygenator of the bubble type so that cross circulation with humans was no longer necessary.[2]

Although this method of extracorporeal oxygenation permitted many operations formerly impossible, there was obviously one shortcoming in it which might be eliminated. This was the beating of the heart. During the conventional by-pass of the heart using the pump-oxygenator with the heart beating, there is a continuous flow of blood from the coronary sinus which may obscure the operating field in the ventricle or atrium even though attempts are made to remove the blood by aspiration. If the by-pass is for a considerable period of time, it is necessary that the aspirated blood be returned to the system and a certain amount of hemolysis and other trauma to the blood is produced. In the open, beating heart, there is danger of air embolism to important systemic arteries. Finally, it is obvious that some of the surgical procedures can be carried out with greater accuracy if the field is quiet as well as dry.

The possibility that some form of drug-induced cardiac arrest might be of value in intracardiac procedures was investigated in our laboratory in the fall of 1952. Our report[3] to the Michigan Heart Association dated January 15, 1953, contained the following paragraph:

"*An Investigation of the Value of Stopping the Heart for Intracardiac Operations:* A solution of potassium chloride has been used to cause an immediate cardiac arrest. The token operation is carried out, after which the heart is started by massage, electrical defibrillation,

From the Divisions of Thoracic Surgery and Pediatric Cardiology of the Henry Ford Hospital, Detroit, Michigan.

The experimental work herein reported was supported by a grant from the Michigan Heart Association.

calcium salts and cardiac stimulants as necessary. This technique has been used in operations of four minutes' duration in which the right side of the heart has been opened. The last five consecutive animals in the series have survived for one month or more with no residuals.

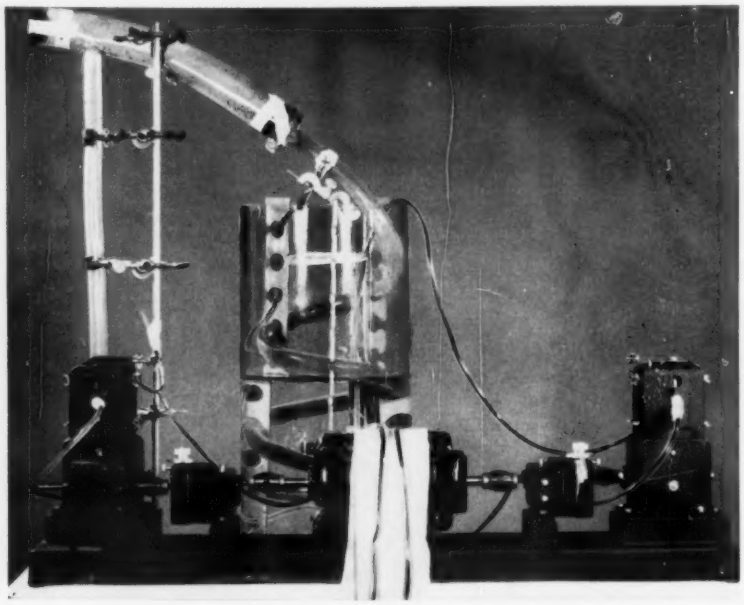

Fig. 1. Pump-oxygenator of the bubble type (Lillehei, DeWall, and their associates). The left head of the Sigmamotor pump removes the blood from the vena cavas and forces it into the vertical oxygenation tube. Bubbles are removed in the larger inclined tube, and the blood collects in the helix in the water bath, where it is removed by the pump head on the right and returned to the aorta.

Operations with the heart asystolic for ten minutes have been done with the aid of cerebral cross transfusion with a donor animal. A study is now in progress to compare the likelihood of recovery of hearts treated in this way with those rendered bloodless by simple vena caval occlusion."

This study went on to include a large number of experimental cardiac arrests in dogs with the nervous system protected by hypothermia rather than cross circulation, and the results were reported in 1955 before the American Association for Thoracic Surgery.[4] Evidence of further progress in the problem was summarized in our report to the Michigan Heart Association dated January 14, 1956:

"Because of the disadvantages of potassium-induced cardiac standstill, which is nearly always complicated with ventricular fibrillation during the period of resuscitation, we have investigated the possibilities of acetylcholine as an "anesthetic agent" for the heart. In acute experiments, this appeared to be the ideal method. With the aorta occluded just distal to the coronary ostia, a solution of acetylcholine was injected into the aorta and thence into the coronary arteries. There was an immediate cessation of the heartbeat. After a variable period of time, heparinized whole blood was perfused through the coronary system and the heartbeat reappeared spontaneously."

Naturally, the reservoir of heparinized blood was soon replaced by a pump-oxygenator which not only supplied an inexhaustible supply of oxygenated blood for the resuscitation of the heart, but also gave protection to the brain and other parts of the body during the period when the heart was out of the circulation. The pump-oxygenator which we first used and continue to use is that of the bubble type devised by Lillehei, DeWall and their associates (Fig. 1). Since April 4, 1956, the combination of extracorporeal oxygenation and induced cardiac arrest has been used in the surgical treatment of 121 patients.

The method of inducing cardiac arrest which we have adopted is illustrated in Figure 2. After the introduction of the cannulas into the subclavian artery and the two vena cavas, they are

attached to the pump-oxygenator and the pump is started. The snares about the caval cannulas are tightened and the level of the blood in the helix of the oxygenator is observed to see if inflow and outflow rates are equal. A non-crushing clamp is placed across both the aorta and pulmonary artery. Acetylcholine in the amount of 10 mg. per kilogram of body weight is injected into the aorta proximal to the clamp. The heart stops when about two-thirds of the solution has been injected but the injection is continued until the calculated dose has been given. Although apparently in arrest, the heart beats when the ventricular well is stimulated mechanically. There is usually no activity during the suturing of ventricular septal defects or operations on the heart valves. No additional acetylcholine is given for the sporadic beats which arise as a result of this direct stimulation.

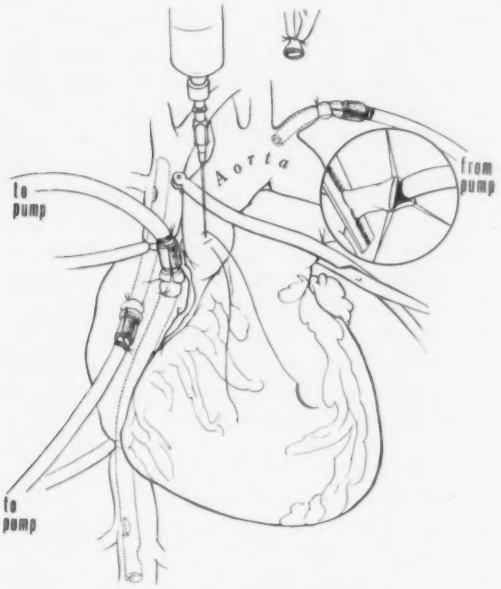

Fig. 2. Diagram of cannulations for the pump-oxygenator, and method of producing cardiac arrest by the injection of acetylcholine into the root of the aorta proximal to a clamp.

Resuscitation of the heart is remarkably simple. The clamp is removed from the aorta permitting the blood from the oxygenator to flow into the coronary arteries. The acetylcholine is washed out of the coronary vessels and escapes into the right auricle through the coronary sinus. It then escapes through the atrial or ventricular incision or if such an incision is not present (as would be the case during an operation on an aortic valve), a path of egress must be provided. A catheter inserted through a small atritiomy is satisfactory. The suturing of the cardiotomy incision is begun as soon as the aortic clamp is removed, and usually a good heart beat is present by the time the incision is closed. If there is delay in the appearance of an effective beat, the final sutures in the cardiotomy incision are also delayed, so that the recuperating heart does not have to work against resistance.

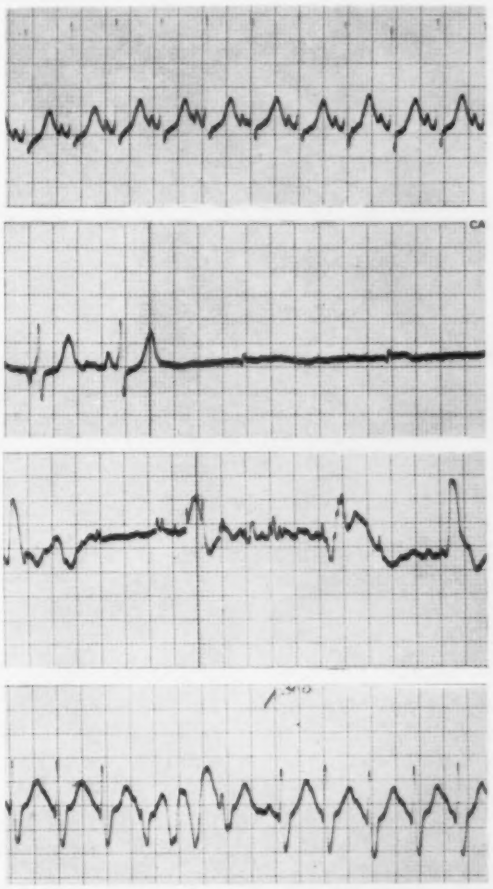

Fig. 3. Electrocardiogram taken during repair of interventricular septal defect in a child of four years. First tracing: before induced arrest. Second: at instant of arrest. Third: during resuscitation. Fourth: after resumption of normal beat.

A typical electrocardiographic record is shown in Figure 3.

Clinical Experiences with Induced Cardiac Arrest

Of the 121 operations in which induced cardiac arrest has been used, seventy-seven were for the repair of ventricular septal defects in seventy-six patients (one patient had a second operation for the repair of a recurrence of the defect). The technical details of these operations have been reported in several articles in surgical journals.[6-9] Induced cardiac arrest has been especially valuable in the repair of ventricular septal defects. In the perfectly dry and quiet field, the sutures can be placed with great accuracy (Fig. 4).

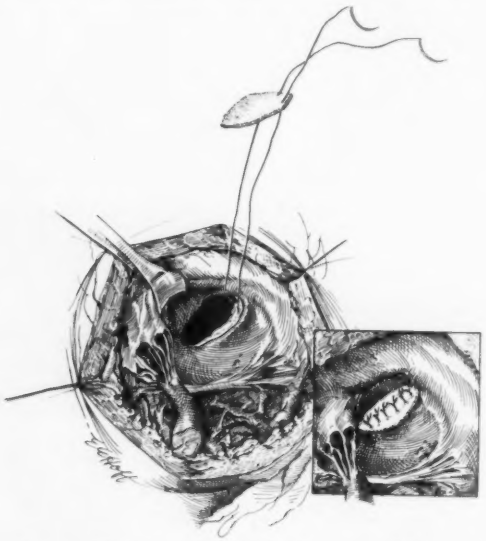

Fig. 4. Diagram of method of suture of interventricular septal defect. Sutures are carefully placed through fibrous tissue, and tied over a pledget of Ivalon sponge.

Restoration of the heart beat has not been a problem in any of the patients. Ventricular fibrillation has occurred infrequently (about 5 per cent incidence), and it has always been converted with one electrical countershock.

The total mortality in the seventy-seven operations for the repair of interventricular septal defect has been 32 per cent (twenty-four cases). There were three deaths in thirty-two patients over the age of three years, and one of these was atypical, with marked underdevelopment of the right ventrical.

Induced cardiac arrest was used in a miscellaneous group of forty-four cases. This list included eight instances of complicated interatrial septal defects of the type commonly called atrioventricularis communis. All but one of these survived the immediate operative procedure, but there were two late deaths with evidence of recurrence of the defect. A prosthesis should have been used in these cases which developed recurrence.

Successful operations have been carried out for the removal of a myxoma of the right auricle, the excision of isolated infundibular stenosis of the right ventricle, anomalous insertion of the veins of the right lung without interatrial septal defect, and the repair of triatrial heart (heart with two left atria and one right atrium).

Operations for the cure of aortic stenosis, mitral insufficiency, and the excision of aneurysms of the arch of the aorta have been done with induced cardiac arrest, but with far less encouraging results, mainly due to the hopeless type of pathologic states encountered.

Summary

Induced cardiac arrest is a valuable adjunct to extracorporeal oxygenation in intracardiac operations. The cardioplegic drug acetylcholine was shown to be very efficient in the experimental laboratory, and it has been used in 121 human operations with satisfaction.

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Some Aspects of Rheumatic Fever

By Donald E. Cassels, M.D.
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SINCE THE clinical manifestations and the treatment of rheumatic fever are fairly well standardized at the present time, it seems more rewarding to discuss some of the broader aspects of rheumatic fever, especially those related to the diagnosis and the incidence of the disease.

Considerable emphasis has been placed on establishing criteria for the diagnosis of rheumatic fever. Not so much emphasis has been placed upon establishing criteria for non-rheumatic signs or symptoms which are usually identifiable and which are commonly confused with the rheumatic fever syndrome. This association of historical, physical, and laboratory findings which alone or in combination simulate manifestations of rheumatic fever can be called the "pseudo-rheumatic syndrome." This is more common than rheumatic fever itself and consequently if this loose association of events can be identified, rehabilitation is simple and prompt and the stigma of disease is promptly removed from the patient.

There are five aspects of the non-rheumatic or pseudo-rheumatic syndrome:

(1) Fever or rather a temperature of 99 to 100 degree Fahrenheit which is normal for young children. It is very common to have a physician see a patient who is ill with a febrile illness and when asked how long a child should stay in bed to answer that he should stay in bed until the temperature becomes normal. For the first time in the child's life, his temperature is then taken regularly every day and it is discovered that it rises to 99° or over every afternoon. This is not fever but the normal temperature of an active young child.

(2) If this temperature range is then associated with leg pain, the question of rheumatic fever is often raised. The typical non-rheumatic pains are nocturnal, they occur behind the knees and in the muscles of the leg, they almost never occur in the arm and the pain usually occurs after the child goes to bed and often is severe enough to awaken him from a sleep. These pains in the legs disappear with massage, with heat or with an aspirin tablet. They are very typical of the pseudo-rheumatic syndrome and are quite different from the usual rheumatic pains which occur during the day and are increased by exercise. The actual explanation of these nocturnal leg pains is not clear but it would seem likely that they are minor cramps and reaction to excess muscle strain.

(3) If in addition to the mild elevation of temperature and leg pain a cardiac murmur is heard, the diagnosis of rheumatic fever is entertained even more seriously. The innocent or functional heart murmurs which occur so frequently in children must be definitely ruled out before the diagnosis of rheumatic heart disease can be entertained. These functional heart murmurs are almost always readily identifiable in the child and will be discussed in more detail.

(4) Non-choreic fidgets and tics are so common in children that they must be considered as part of any young child's activities. However, an active squirming disinterested child in school is frequently labeled as "nervous" and the next step is to raise the question of the presence of Sydenham's chorea. Choreic movements are so non-repetitive and so characteristic that repetitive facial grimaces or tics are not easily confused, although it is perfectly true that the fidgety child may also have chorea and consequently the disease may be ignored for sometime.

(5) The pseudo-rheumatic syndrome is completed by borderline laboratory abnormalities. These are abnormalities in terms of elevation of the white blood count, or the sedimentation rate, and borderline abnormalities of the electrocardiogram. The normal values in these three categories, which are commonly used to substantiate the diagnosis of rheumatic fever, are not as rigid in children as they are in adults. For instance, the white blood count rises much more readily in children, and the sedimentation rate is elevated much more easily. The values of the sedimenta-

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Presented at the heart and rheumatic fever block supported by the Michigan Heart Association, at the Michigan Clinical Institute, Detroit, March, 1957.

tion rate based in general on the basis of finding in adults are not readily applicable to children and values of the sedimentation rate up to 25 mm. per hour are not remarkable in children and cannot, as isolated findings, be considered as representing chronic infection. Where serial determinations are available the criteria can be more rigid. However, isolated determinations have to be interpreted with some caution, usually erring on the side of being liberal. In medicine as in law the patient is innocent until proven guilty.

The murmurs of rheumatic heart disease are usually identifiable and are quite different from the functional murmurs so commonly heard in childhood. There are simple rules which are readily applicable and which have only a few exceptions. (1) Isolated apical murmurs in children either systolic or diastolic are rheumatic in origin until proven otherwise. (2) Murmurs at the base in the first, second or third interspaces either on the right or left are non-rheumatic when they occur alone. (3) The exception is the murmur of aortic regurgitation which is diagnostic even in the absence of auxiliary peripheral signs. There are very few exceptions to these rules and it is difficult in a child to establish the diagnosis of aortic stenosis which has occurred on a rheumatic basis.

The most difficult of the childhood murmurs, which I have called an "undiagnosed murmur," is a systolic murmur of about Grade II intensity heard along the left sternal border from the second left interspace to or beyond the apex. There is no point of maximum intensity and no change in character with position or manipulation of the thorax. In seventeen patients with this murmur followed for about five years or more, the murmur became localized at the second left interspace in fifteen and the murmur became localized at the apex in two patients.

No patient developed rheumatic signs or symptoms. This complex and difficult-to-diagnosis murmur is then almost surely non-rheumatic in origin. Only in a small percentage of patients will this murmur localize at the apex and thus, by the simple clinical rules, be considered as representing rheumatic heart disease.

Sometimes cardiac murmurs can be manipulated and changed so that they are either augmented in intensity and can be considered as representing organic heart disease or become so lessened in intensity (sometimes to the point of disappearing completely) that they can be considered as non-organic in origin. Especially in young children with a cartilaginous thorax which is easily movable, compression of the precordial area will sometime change the murmur rather remarkably. This is a useful procedure as part of a routine examination of the heart.

The position and areas of maximum intensity of cardiac murmurs in a child may be described as follows: Area 1 over the anterior fontanelle applies only to infants and can be ignored. Area 2 about at the mastoid process is a common place for systolic murmurs of considerable intensity and these murmurs occurring in normal children should not be confused with the real murmur of an arteriovenous fistula which can occur in the same area. Area 3 represents about the point of the jugular bulb, the point of common venous hum which is present at one time or another in most normal children.

This murmur is frequently sufficiently loud that it radiates below the clavicle and is heard as a systolic murmur in the first and second interspace on the right and also the first and second interspace on the left. Some substantiation of this point of view is found by a simple maneuver. If the precordial murmur disappears when the venous hum is obliterated by pressure, it seems reasonable that there is some relation between these two murmurs. This is the common murmur of childhood and this manipulation, commonly, almost or completely obliterates the murmur maximum in the second and third left interspace. If this maneuver is successful in reducing the precordial murmur it is argued that the precordial murmur is extracardiac in origin and is not related to any organic disease.

A separate and different systolic murmur is sometimes heard above the clavicle, also, especially in the right super clavicular area. This is systolic alone, it changes less in maneuver, and is thought to arise as in arterial murmur. Sometimes this changes with the manipulation of the arm and the clavicle and most likely arises at the point of branching of the great vessels in the neck either or as the carotid arises from the innominate at peculiar angles.

Area 6 represents the murmur mentioned previously as an undiagnosed murmur, a short systolic murmur not accompanied by any change of heart sounds which is heard in the second left interspace and is heard without change in in-

tensity of quality to the apex. Since there is no localization and since it changes very little with maneuvers of the neck, the head, or the thorax, no indication of the point of origin can be obtained. This murmur in the course of time, is almost always localized at the second left interspace making it non-rheumatic in origin, unless isolated pulmonary stenosis acquired on a rheumatic basis, should be considered. This is not considered likely, however. Area 7 is, of course, a common site of murmurs of rheumatic origin and a murmur maximum at the apex is rheumatic in origin unless it is definite that some other etiology can be ascribed to it.

The common functional murmurs of childhood are thought to be recognizable in most instances and the residue of murmurs heard are either those of congenital heart disease or those of rheumatic heart disease. The problem then becomes one of separating these two types, which usually is not difficult.

Using the criteria discussed, the diagnosis of 300 new patients seen at a rheumatic fever clinic of The Division of Services of Crippled Children of Illinois, was examined. The clinic is a diagnostic clinic and accepts only patients referred by a physician. The social-economic status of the referrals vary considerably and it is believed that the patients seen represent a cross section of children in the midwest. The distribution of patients by diagnosis is shown in Table I.

TABLE I. DIAGNOSIS OF 300 NEW PATIENTS
Chicago Heights Rheumatic Fever Clinic Division of Services of Crippled Children

No Disease	Undiagnosed Murmurs	Functional Murmurs	Heart Disease			Potential Heart Disease (History or Evidence of Rheumatic Fever)
			Rheum.	Cong.	Misc.	
30	17	100	36	63	5	44

About one-third of the patients referred to this children's diagnostic cardiac clinic had functional murmurs only. Most of these were murmurs heard during school or pre-school examinations although some of them were heard incidentally during medical care for some other illness. About one-third of the patients referred to the clinic had some variety of organic heart disease. Slightly less than one-quarter of the patients seen, had a history or physical findings substantiating the diagnosis of rheumatic fever or of rheumatic heart disease.

It is thought that this clinic is so representative that the figures give a very good indication of the status of children in the midwest who are under suspicion of having rheumatic fever; or who have a cardiac murmur; or who have frank organic heart disease. About 10 per cent of the referrals had no indication of disease of any kind and were seen for the purpose of making the diagnosis of no disease.

DOCTOR FEES BELOW OTHER HEALTH COSTS

A report in the *Monthly Labor Review* on medical care costs in the cost of living index notes that, in the past twenty years, hospital costs have risen sharply in contrast to physicians' fees. The article by a Bureau of Labor Statistics employe lists these increases between 1936 and 1956: hospital room rates, 264.8 per cent; dentists' fees, 82.1 per cent; general practitioners' fees 72.8 per cent, and surgeons' fees, 59.5 per cent. In the same period, medical care costs generally have lagged behind costs for food, personal care other than medical and clothing. The report makes this observation: 'With the higher level of living attained in 1950, relative expenditures for medical care tended to increase as incomes increased, as is usually true of items considered as "necessities" in the family budget. The fact that this pattern has begun to appear in the spending of workers' families indicates the high order of importance they place on medical care. . . .' "—*Insurance Economics Surveys*, November, 1957.

Acute Myocardial Infarction

Pain Clues Often Overlooked

By Robert H. Berman, M.D.
Detroit, Michigan

A LARGE percentage of the cases of acute myocardial infarction present a classical, almost pathognomonic, pain syndrome. This syndrome, as most physicians know, consists of acute severe to excruciating anterior diffuse retrosternal or left chest pain, squeezing, pressing or crushing in character, with or without radiation from the chest, lasting an hour to many hours, with the patient moving or twisting about in anguish. However, an equally large group of cases presents a non-classical picture. This latter group conveys no pathognomonic picture. Since many other diseases give symptoms similar to this latter group, the diagnosis of acute myocardial infarction is often missed or made belatedly.

The following cases exemplify the types of pain involvement which are often overlooked as clues to acute myocardial infarction.

Case Reports

Case 1.—This patient, a fifty-five-year-old scientist, phoned and stated that for the past few days he had had a burning sensation in his mid-chest and epigastrium. He asserted emphatically that his symptoms were not painful, only burning and distressing. He was sure that they were due to some gastrointestinal disturbance. He had continued his work without limitation. There was no prior history of cardiac involvement nor of previous hypertension or diabetes. A routine electrocardiogram a year ago was normal. Examination disclosed no abnormal findings although he appeared haggard. Blood pressure was 120/80. His previous pressure had been 145/90. The difference was small but suggestive. An electrocardiogram, however, revealed changes consistent with a posterolateral and inferior myocardial infarction (Fig. 1). He was hospitalized and made an uneventful recovery.

Comment.—This first case illustrates the fact that often, in acute myocardial infarction, the patient does not use the term "pain"; and in fact will often voluntarily state that he has no pain.[1] It illustrates also the fact that often the pain or sensation complained of is distressing but not agonizing, and the patient is able to pursue his usual activities. If his discomfort lasts only an hour or two, he may not seek medical advice. His infarction may only be revealed at some later date if residual electrocardiographic changes persist.[2] This case also points out a well-known fact that pain in acute myocardial infarction is often described by patients in many other terms.[1,3] The most frequent of these are burning, indigestion, heaviness, weakness, fullness, tightness, aching, numbness and tingling. "Inability to breathe" is a frequent phrase. Questioning will usually elicit the fact that there is not true dyspnea unless left ventricular failure accompanies the infarction.

Almost every person today who experiences the classical pain syndrome is aware that he may have a heart attack and at once consults a physician. However, when he experiences the other sensations that have been enumerated, he usually is not aware of the fact that these sensations may be due to heart disease.

Case 2.—A fifty-three-year-old attorney had had two previous infarctions. Since the last one, he had been seen numerous times because of episodes of acute coronary insufficiency. These usually consisted of pressing and burning mid-sternal pain radiating to the left shoulder. The pain was of moderate intensity and was always relieved in one-half to one hour by rest and sedation. His wife phoned one day stating that he was having a similar attack, but that the pain seemed to be worse than usual. When seen at home an hour after the episode had started, pain was still present in undiminished degree. The patient appeared uncomfortable but was quiet. Examination was negative. Blood pressure was 140/90, his usual pressure. In view of the fact that the attack was more severe than usual and that the patient seemed weaker than in previous episodes, an infarction rather than another acute coronary insufficiency was considered probable. He was therefore hospitalized. Initial electrocardiogram showed an acute injury ST in aVf, and a repeat the next day revealed a QaVf compatible with inferior myocardial infarction. Serum glutamic oxalacetic transaminase test on admission was eight units, the second day 260 units, the third day 60 units. The diagnosis might have been inferred from these serial transaminase changes alone.[5] Electrocardiogram on the third day revealed auricular ventricular block with Wenckebach syndrome. He made a

good recovery. He was continued on anticoagulants after discharge (Fig. 2).

Comment.—This case demonstrates the need of carefully watching the patient with frequent acute coronary insufficiency episodes so as to diagnose the acute myocardial infarction that often replaces them. Changes in the acute coronary insufficiency symptoms that are often significant clues are: variations in the distribution of pain, an increase in the intensity or duration of pain, the occurrence of arrhythmias or cardiac failure, sweating, nausea and vomiting if they have not occurred before, and a drop in blood pressure. These changes apply to angina pectoris as well as acute coronary insufficiency.[4] It is true that many cases of angina pectoris or acute coronary insufficiency will present these changes in their attacks without acute myocardial infarction, but these changes should alert the physician. He should not be disturbed if he is in error occasionally (or even frequently) in clinically suspecting changes as due to acute myocardial infarction. Fortunately today, one has additional help in eliminating the suspicion of acute myocardial infarction by the use of serial serum glutamic oxalacetic transminase tests.[5,6] These tests are especially helpful when, as often happens, the electrocardiograms are indecisive the first few days.

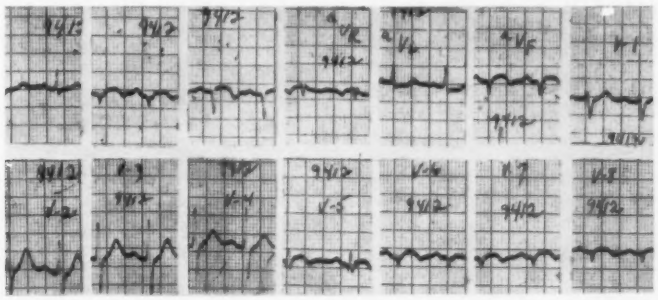

Fig. 1.

Case 3.—A fifty-nine-year-old executive, while being treated by his dentist, suddenly developed severe persistent pain in both arms while in the dental chair. He was seen in the office and a diagnosis of possible acute myocardial infarction was made. An electrocardiogram the next day manifested the changes of an acute anterior infarction. The pain on the second day had changed to the retrosternal area and persisted almost the entire day. He expired on the second day. A history of attacks of mild precordial pain for the past few years was later obtained from his family physician.

Comment.—This case portrays the fact that the pain of acute myocardial infarction may be absent from the anterior chest and localized in other areas.[7,8] Cases are seen frequently where the only pain is in one arm, both arms, or only the shoulder or other areas of the arms; or in the neck, gums, jaw or teeth; or in the interscapular area. Very often the pain may be limited to the epigastrium. In rarer cases it may be limited to the ears. This peripheral involvement may be in any combination. It may be replaced by anterior chest pain. Epigastric pain, since it so often appears in acute myocardial infarction with nausea and vomiting, often beguiles the physician into centering his attention on gastrointestinal involvement. In one of the very early reports on myocardial infarction, epigastric pain was noted as the only symptom in a majority of the cases.[9] Gum, jaw and tooth pain often impel the patient to see a dentist before he sees a physician. Localized arm or shoulder pains often mislead the

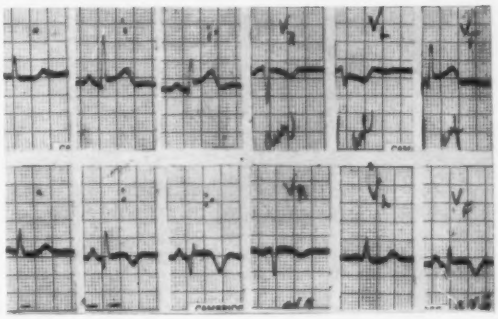

Fig. 2. (*Upper row*) Limb leads on first day. (*Lower row*) Limb leads on second day.

physician by suggesting arthritis or bursitis. Pain in these areas noted in patients in the coronary age range should be a clue to the physician to include acute myocardial infarction in his differential diagnosis.

Case 4.—An eighty-six-year-old man, retired, was seen at his home in a comatose state. No definite immediate story could be obtained. except a questionable one of epigastric pain before he became comatose. Though he was unable to respond to questions, he kept rubbing the lower sternal area. Examination was negative except for a blood pressure of 60/0.

The diagnosis of acute myocardial infarction seemed likely, though many other diagnoses had to be considered. An immediate electrocardiogram at the hospital showed a right bundle branch block, slight auricular ventricular block, and changes compatible with acute anterior septal infarction. His serum glutamic oxalacetic transaminase test was verbally reported as over 3000 units, an unusually high level. The written report was apparently lost. Levophed temporarily restored his blood pressure to a satisfactorily level. After about twelve hours, Levophed and other drugs became ineffectual. Death ensued the same evening. Autopsy revealed an acute infarction involving the septal and anteroseptal areas of the left ventricle.

Comment.—This case demonstrates the problem of hidden or obscured pain. Probably nearly every patient with shock or coma due to acute myocardial infarction has had pain or sensation-substitutes. In many cases pain symptoms could doubtless be elicited if the patient's sensorium in shock were clear.[10] Many have reported cases of acute myocardial infarction without pain.[11,12] Doubtless a few cases occur. It is probable, however, that in many cases of acute myocardial infarction where there seems to have been no pain, the various sensations that represent pain have been overlooked. In shock or coma the absence of any pain history does not eliminate acute myocardial infarction as a cause of the shock or coma.

One must also keep in mind the fact that an acute myocardial infarction may, conversely, be caused by the effects of shock. The electrocardiogram and serum glutamic oxalacetic transaminase test may reveal or confirm acute myocardial infarction in shock or coma.

Summary

1. Some clues which should evoke the consideration of acute myocardial infarction in the differential diagnosis have been discussed. These clues include chest sensations which are not described as pain by the patient; changes in the usual pain pattern of the patient with acute coronary insufficiency; pains limited to areas other than the anterior chest.

2. Pains or equivalent sensations due to acute myocardial infarction are often obscured by shock or coma. If the etiologic diagnosis is not certain, the patient in shock or coma, who is in the coronary age range, should have serial electrocardiograms and serum glutamic oxalacetic transaminase tests.

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Auricular Infarction

By Jack M. Kaufman, M.D.,
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INVOLVEMENT of the auricular myocardium by infarction was generally thought to be exceedingly uncommon until 1942. At that time, Cushing and his associates reported their observation of thirty-one instances in a series of 182 cases of myocardial infarction.[1] This was the first work to suggest the more probable frequency of this disease. Although the electrocardiographic changes incident to auricular infarction were initially described in 1939,[2] it was seventeen years later (1946) when the first reported attempt towards an ante-mortem diagnosis appeared in the literature.[3] This case, while showing characteristic electrocardiographic changes (since found to be classically demonstrable of auricular infarction) did not substantiate this diagnosis by postmortem studies. Hellerstein, in 1948, was credited as having made the first diagnosis of auricular infarction to be proved by autopsy.[4] Again, in 1954, Wilson and Knudson correctly diagnosed an auricular infarct ante mortem.[5]

The incidence of infarction of the auricles (either as an isolated finding or concomittant with ventricular infarction) varies, according to several larger series reported, from less than 1 per cent to 24.5 per cent.[1,6,7,8] The average seems to be in the vicinity of Cushing's reported 17 per cent. It would seem, then, that the actual occurrence of auricular infarction, either alone or as a complication of ventricular infarction, is probably fairly common. In the literature available to us, however, we have been able to find only two authenticated cases correctly diagnosed before death. Our purpose in this paper is to present another case the diagnosis of which was established ante mortem and confirmed at autopsy.

Case Report

H. N. (A-222952), a sixty-two-year-old white man was admitted to Harper Hospital on July 27, 1956 complaining of a sudden onset of nausea and vomiting three hours prior to admission, followed by left anterior chest pain which radiated into the left shoulder and arm. The pain persisted in spite of nitroglycerin therapy. On admission, however, he obtained considerable relief from parenteral morphine and atropine. He claimed to have had three similar episodes eight years ago, but apparently had not been seen by a physician at that time. Past history and review of symptoms was otherwise noncontributory. He denied previous hypertension.

Physical examination revealed an elderly man in acute distress with chest pain. No cyanosis or pallor was observed. Blood pressure was 100/60; pulse, 46; respiration, 16 per minute; and temperature, 100.8° F. The head, eyes, ears, nose and throat were normal as was the neck. The chest was symmetric. Lungs were clear to percussion and auscultation. No rales were audible. The borders of cardiac dullness were within normal limits. No thrills, rubs, abnormal pulsations, or murmurs were discovered. The heart sounds, however, were quite distant. While the rhythm was regular, a rate of 46 per minute was found with varying intensity of S 1, at the apex. Results of examination of the abdomen, back, rectum, genitalia, extremities, and skin were considered negative. Neurologic examination was uninformative.

The white blood count on admission was 16,500 per cu. mm. with 76 per cent neutrophils. Sedimentation rate (Westegren) was 28 mm. per hour. Fasting blood sugar was 116 mgm. per cent; and non-protein nitrogen, 48.3 mgm. per cent. Urinalysis revealed a 4+ albuminuria with a few hyaline casts per high powered field.

The admission electrocardiogram (July 27, 1956) was interpreted as follows: Complete heart block, acute auricular myocardial infarction, and acute posterior myocardial infarction (Fig. 1). On the evening of admission, the patient converted to a normal sinus rhythm. Electrocardiograms on July 28, 1956 and July 29, 1956 showed progressive changes of acute posterior infarction in the presence of a normal sinus rhythm and occasional ventricular premature beats. On July 30, second degree heart block and Wenkebach's phenomenon with trigeminy was observed. Moreover, at the end of the tracing, beginning auricular fibrillation was recorded (Fig. 2). By July 31, the rhythm was again found to be basically regular with frequent supraventricular extrasystoles and a wandering pacemaker. On the following day, no abnormality of rhythm was detected.

Although the patient's hospital course had been relatively uneventful, on the sixth hospital day he suddenly cried out in pain and was found to be in shock, pulseless, and cyanotic. A few minutes later, he was pronounced dead.

Postmortem examination was performed by Dr. Plinn Morse, chief of the pathology service of Harper Hospital. He reported the heart to weigh 360 grams. The posterior aspect of the heart was diffusely covered with

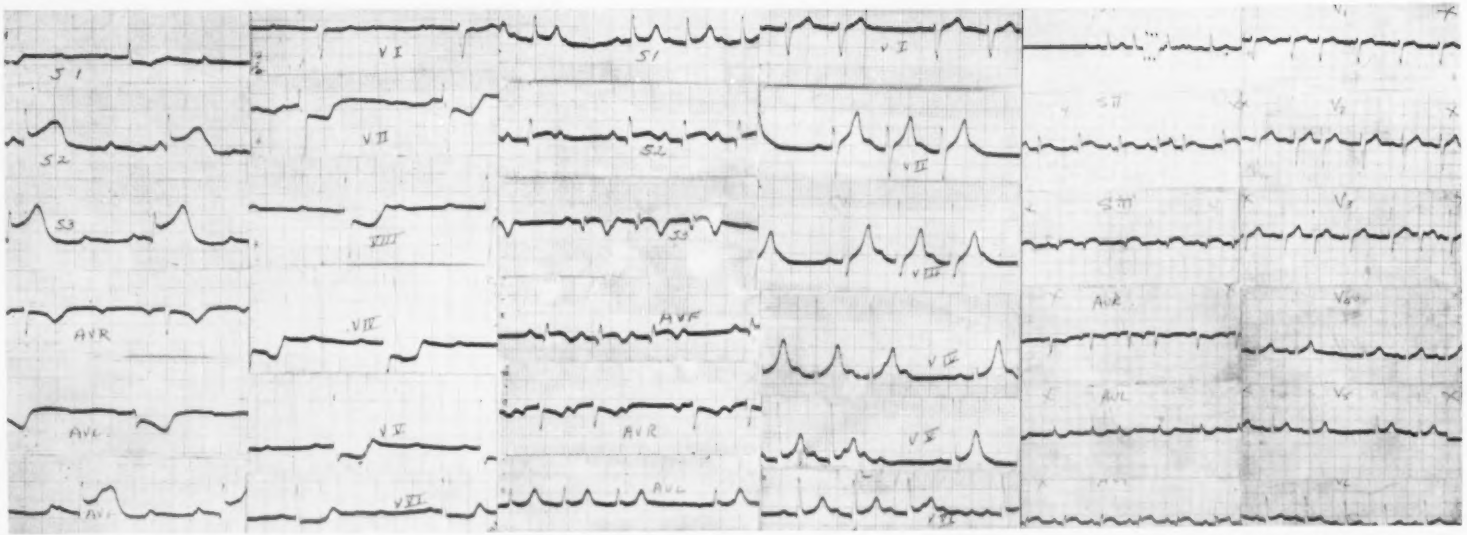

Fig. 1. July 27, 1956: Complete AV block, acute auricular infarction; and acute posterior myocardial infarction. Auricular rate 100; ventricular rate 40. P waves independent of QRS complexes with elevated PTA segments and upright T waves having an elevated take-off in 2, 3, and AVF_2. Depressed in 1, AVL, V_1, and V_6.

Fig. 2. July 30, 1956: Second degree heart block with Wenkebach's phenomenon, and resultant trigeminy. (4 auricular to 3 ventricular beats). At end of tracing, auricular fibrillation beginnings. P waves and PTA segment now normal. No PTA waves visible. Note the waxing phase of posterior myocardial infarction.

Fig. 3. July 31, 1956: Wandering pacemaker with frequent supraventricular extrasystoles. No demonstrable abnormalities of auricular repolorization. Further evolution of posterior infarction.

fresh fibrinous adhesions. The atrioventricular sulcus, and left atrium, were intensely discolored with hemorrhagic infiltration and were found to feel much softer than the remainder of the myocardium. The endocardium was normal except for that of the left ventricle which was involved by a large mural thrombus. Both major coronary arteries were severly atherosclerotic, revealing several recent thrombi in the right coronary artery.

The autopsy was otherwise unremarkable except for acute congestion of the lungs, liver, spleen and kidneys. The kidneys were grossly involved with atherosclerosis.

In addition to findings typical of infarction of ventricular myocardium, microscopy revealed a recent infarction of the left posterior auricular wall. This was evidenced by absence of myocardial structure and the presence of cloudy swelling with pyknotic nuclear degeneration. The lesion was further characterized by edema and round cell infiltration primarily lymphocytic in type (Fig. 4 and 5).

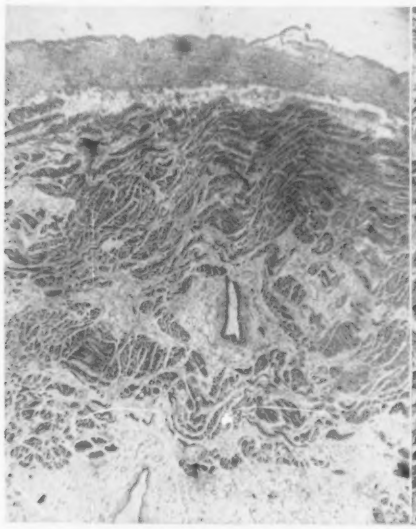

Fig. 4. Auricular myocardium and endocardium. Note disrupted pattern of auricular myocardial structure. Note also the subendocardial "spared zone" of Soderstrom.

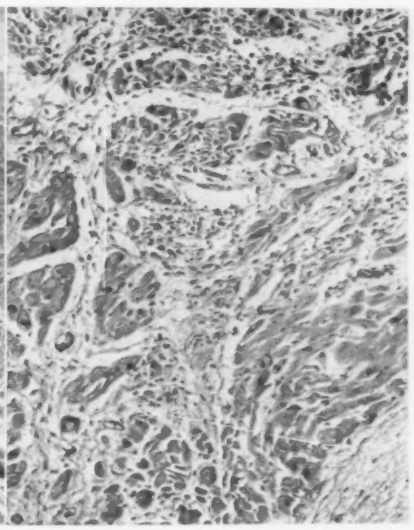

Fig. 5. Infracted auricular myocardium with degeneration of myocardium, round cell infiltration and edema.

Discussion

Since there is no suggestive symptom complex, the diagnosis of auricular infarction must depend on electrocardiographic evidence alone. This involves, primarily, the detection of various arrythmias which are usually transient and rapidly changing. They occur in over 75 per cent of the cases of atrial disease while only 9 per cent of the cases of "pure" ventricular infarction are so characterized.[1] The variations in the auricular mechanism include fibrillation, flutter, extrasystoles, tachycardia, sinus arrest, wandering pacemaker, and atrioventricular nodal rhythm. Disturbances in conduction are not uncommon. Any degree of heart block including Wenkebach's phenomenon may be detected. In our cases we recorded transiet complete heart block, auricular extrasystoles, auricular fibrillation, Wenkebach's phenomenon, and wandering pacemaker (Fig. 1, 2 and 3).

While Hagen insists that we must rely on the arrythymias alone, most investigators agree that deviation of the PTa segment, with or without a changing contour in the P and PTa waves, is also indicative of auricular infarction. The P and PTa waves may be broadened, slurred, notched, or a change in amplitude may be detected. Normally, the terminal portion of the PTa segment, the auricular T wave, is "buried" in the succeeding QRS complex. Therefore, to evaluate the complete cycle of auricular activity including this portion of the electrocardiogram, some delay in atrioventricular conduction or, (ideally) complete atrioventricular block must coexist.

Perhaps most significant in the diagnosis of auricular infarction is PTa segment displacement.

Gross has noticed that this segment may normally be elevated in direct proportion to the cardiac rate and to the size of the P wave, particularly when the rate exceeds ninety per minute.[10] Abramson has shown, however, in experimental animals that PTa segment displacement may also represent auricular damage.[11] Whether the PTa segment is elevated or depressed depends on the site of auricular involvement. Elevation of this segment is seen in the leads reflecting the potentials of the anterior auricular myocardium (I, AV1, and the precordial leads) when this portion of the auricles is infarcted. Moreover, there may be reciprocal depression in the posterior leads (II, III, and AVF). Conversely, in posterior auricular infarction, the PTa segment may be elevated in the posterior leads with reciprocal depression in the anterior leads.

It would seem that the right auricle and particularly the right auricular appendage have a predilection for infarction.[1,6,7,8] Since, according to Hellerstein, the right auricular appendage assumes an anterior or anterolateral position in the thorax, one would expect a predominance of electrocardiographically anterior auricular infractions. Cushing found this to be true in twenty-eight of his thirty-one cases. However, in this report, two of the three cases mentioned to have been diagnosed ante mortem, were posterior.

Electrocardiographic findings are not limited to those indicating changes in auricular activity. Associated QRS abnormalities, ST segment and T wave changes are the rule since atrial infarction usually occurs concomittantly with ventricular disease.[1,7]

Acute infarction of the auricles has more than an academic significance. A reported 80 to 84 per cent of such cases are eventually complicated by mural thrombosis.[1,6] This may be due to the involvement in a preponderant number of cases of that portion of the myocardium that harbors the most stagnant intracardiac blood; that is, the auricular appendages. This is especially true of the right appendage "honeycombed" with a greater number of trabeculations.[6] It seems inevitable that such a frequent occurrence of mural thrombi in the right auricle, would commonly result in pulmonary thromboembolism. This has been reported in as many as 24 per cent of the cases in certain series.[7]

It is conceivable that the treatment of auricular infarction might be more demanding than the treatment of myocardial infarction, in general. It is interesting to speculate on the advisability of auricular appendectomy subsequent to the acute phase of this disease. Somewhat less speculative is the mandatory and immediate institution of anticoagulation therapy upon diagnosing an acute auricular infarction. Continued post-hospital medication for anticoagulation would also be advised.

Summary

The third known case of acute auricular infarction to be correctly diagnosed ante mortem is presented. The literature is reviewed, the incidence, diagnosis, significance and treatment are discussed.

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Experiences in the Development of a Satisfactory Pump Oxygenator

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THE INITIAL efforts at the University of Michigan to develop an extracorporeal unit were directed toward the construction of a simple and inexpensive blood oxygenator. The successful experience of DeWall,[1] Nelson,[2] and others,[3-5] with the bubble-type oxygenator indicated that a modification of their apparatus would fulfill our requirements.

Description of Plastic Bubble Oxygenator

The model illustrated in Fig. 1 was constructed of clear lucite. This oxygenator is simple to build and it has no moving parts. The unit is a cylinder located concentrically within a larger cylinder. The inner cylinder is the oxygenating column which measures 5 cm. in diameter and 41 cm. in length. The outer cylinder, which acts as the blood reservoir, is 13 cm. in diameter and 50 cm. in length. A screw cover fits the top of the oxygenator to prevent entrance of foreign material. It is desirable to drill a hole in the center of the plastic cover so that blood may be added to the reservoir if rapid blood replacement is necessary during open cardiotomy.

Description of Propulsion Unit

The propulsion unit is a double headed Sigmamotor pump.* This pump is illustrated in Figure 2. The pumping system consists of two separate finger pumps which are driven by an explosion-proof motor. Each pumping head may be regulated by a separate speed vernier which allows accurate control of blood flow. This pump is responsible for certain measurable amounts of hemolysis but these values have not been high. For periods of one hour or less of cardiac by-pass, we believe this pump to be safe.

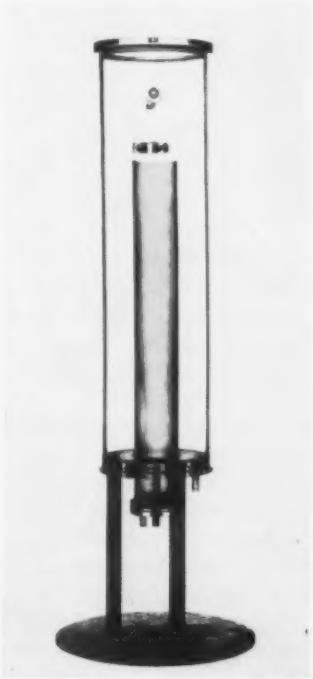

Fig. 1. Lucite oxygenator with central oxygenating column and large outer blood reservoir.

Extra-cardiac Tubing and Connectors

Polyvinal plastic tubing is used throughout the system. The ventricles or tubes that are compressed by the finger pumps are the large type constructed of flanged Silastic. The connectors and adaptors are made of nylon with smooth inner surfaces. Plastic tubing, plastic connectors, and the large Silastic ventricles are utilized primarily to minimize damage to the blood elements. All

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Presented before the Michigan Chapter of the American College of Surgeons, Ann Arbor, March 12, 1957.
Dr. vanderWoude is a Fellow of the Michigan Heart Association. Dr. Burge is a Fellow of the National Heart Association and the United States Public Health Service.
*Sigmamotor, Inc., Middleport, New York.

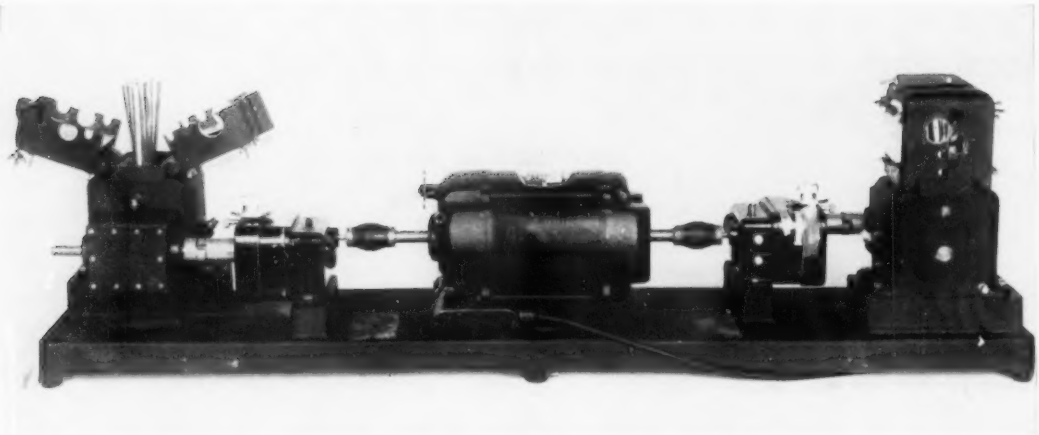

Fig. 2. Sigmamotor propulsion unit for complete cardiac by-pass. Note open finger compression head at left.

connectors lock with a screw nut and cannot come apart.

Operation of the Bubble Oxygenator

The operation of this oxygenator is not difficult. Oxygen is delivered to the inner column at its base through a lucite tube which has twenty holes bored in its distal 3 centimeters. Holes with an inside diameter of a No. 18 needle have been most satisfactory. The rate that oxygen is delivered to the blood is determined by the flow rate required by the patient, by the size of the oxygenating column, and the size of the holes through which the oxygen is delivered. Nelson has determined that approximately one liter of oxygen per 100 ml. of blood flow per kilo is necessary to obtain satisfactory oxygen saturation. Generally we have delivered oxygen to the oxygenator at rates similar to those suggested by Nelson.

Venous blood enters the bottom of the inner column through a connector ¼ in. in diameter. As the blood is pumped into the inner cylinder, it encounters and is mixed with rising bubbles of oxygen which are readily taken up by the desaturated hemoglobin. When the blood reaches the top of the inner column it spills over into the outer reservoir. The bubbles which spill over with the blood into the outer cylinder are mostly eliminated in their descent by the antifoam which covers the inside of the oxygenator. A recent addition of a plastic scouring sponge as a cap on the inner column has eliminated any bubbles from the outer reservoir. This same plastic sponge has also increased the oxygenating capacity of the inner column by retaining the blood for a longer time in an oxygen-rich atmosphere.

Laboratory Studies Following Cardiac By-pass

The effect of pump and oxygenator on the blood elements and blood chemistry must be known and taken into account. The degree of hemolysis in our experimental animals and patients has been well below the 300 mgm. per cent considered harmful. Animals in the laboratory sustaining cardiac by-pass for 30 minutes showed a mean hemolysis of 40 mgm. per cent and for perfusions lasting up to one hour, values have not exceeded 100 mgm. per cent.

Bleeding and clotting times studied before and two hours after perfusion have been normal. Platelet counts show a decrease from normal values but not to a dangerous degree. A normal platelet count of 300,000 in the normal subject may decrease to 200,000. DeWall[6] has studied the platelet response to perfusion and has noted changes similar to those we have found. The white counts following perfusion also show a temporary decrease.

Studies on the life of a red cell reveal it to be markedly shortened after perfusion with various types of oxygenators.[7] It is important therefore to follow hemoglobin levels closely in the postoperative period.

A predictable drop in the arterial CO_2 content is noted after cardiac by-pass and studies of the pH concentration reveal little change from normal. It should be emphasized that blood pH values alone result in an incomplete picture as

they may be normal or on the alkaline side of normal despite a gain of fixed acids in the blood. This rise in free acids in the blood is noted by a study of lactic acid which is increased after perfusion.[6] It is of considerable interest that these blood gas and acid base changes are well tolerated by laboratory animals and patients.

Control of Postoperative Hemorrhage

In our experience, the most important requisite in the prevention of postperfusion hemorrhage and restoration of normal clotting mechanism is complete reversal of heparin with protamine sulfate. This is accomplished by administering protamine in the same dosage as used for heparin. We have not encountered bleeding difficulties when heparin has been neutralized in this manner, but we also recognize the importance and perhaps greater accuracy of the control of bleeding by the use of protamine sulfate titers.[8] Although postoperatively, fresh blood seems effective in preventing bleeding, it has not been found necessary since added experience has been gained in the administration of protamine. Prior to perfusion the dosage of heparin is 1.5 mgm. per kilo of weight. Blood used to prime the oxygenator is prepared with 18 mgm. of heparin per 500 ml. of blood.

Suggestions for Successful Use of the Bubble Oxygenator

The successful use of this oxygenating system demands close attention to certain details which became apparent as our experience increased with its use in the laboratory. We believe that most satisfactory results in the laboratory and clinical use depend on blood flow rates in the range of 50 to 70 ml. per minute per kilo of body weight. Our earlier experience with the low azygos flow rates[9] of 15 to 30 ml. per minute per kilo were less encouraging because of the narrow margin of safety afforded to brain tissue. Kaplan[10] has recently demonstrated that the reduction in oxygen availability associated with extremely low blood flow rates may approach levels only slightly in excess of those resulting in brain damage.

Another important feature in the successful use of the bubble oxygenator is the constant maintenance of a large blood reservoir in the outer collecting column. No less than 600 ml. of blood should be maintained in the reservoir during a perfusion, and it is our custom to keep a level of 1,000 ml. during by-pass procedures. Such a large blood reservoir prevents air bubbles and fibrin clots entering the cerebral vessel. The air bubbles which may pass into the outer reservoir are always near the surface and in the presence of a large reservoir cannot be drawn into the arterial circuit. Any fibrin emboli which may be formed will remain on the surface of the blood in the reservoir.

Additional safety devices which have been added to the apparatus are a blood filter and a plastic bubble trap. The bubble trap is placed between the propulsion unit and arterial catheter while the filter screen is positioned in the outer blood reservoir.

Coronary blood encountered in open heart surgery may amount to an unexpectedly large volume which must be removed at the time of cardiotomy. Although in our method the coronary blood is not returned to the oxygenator, this could easily be done by the use of another Sigmamotor pump which would recover the coronary blood and return it to the venous side of the oxygenator. If controlled asystole[11] is used, there is no coronary flow to cause concern.

Mechanical and technical errors are especially to be avoided. A check for loose connectors and tubing must always be carefully made before each perfusion and new polyvinal tubing is used for each procedure.

The oxygenator is carefully cleaned and examined for any residual blood or fibrin clots before final sterilization. Although we have not experienced pyrogenic reaction following sterilization of the plastic oxygenator, this has been noted by others.

Technical errors are concerned with proper placement of the arterial and venous catheters. Both caval catheters are inserted through the atrial appendage or atrial wall. These catheters must not be so soft as to be occluded by pumping suction or too large to prevent atrial filling before the cava are occluded during perfusion. The arterial catheter is inserted into the femoral artery. It is important in handling this vessel to avoid spasm as this will prevent or limit insertion of the desired size catheter into the vessel lumen. The left subclavian artery may also serve as an entrance for the arterial catheter.

Blood prepared by the blood bank should be filtered before it is pumped into the oxygenator. Improper preparation of donor blood may result

in clot formation that would impede or completely prevent forward flow in the outflow tubing.

Air may pass through a septal defect into a left heart chamber during open cardiotomy. This difficult problem has been partially solved by various means. A catheter may be inserted into the left ventricle to afford an avenue for trapped air to escape. A large volume of saline poured into the heart chamber prior to closure of a septal defect will force air to rise from the chambers and thus prevent air emboli passing to the coronaries or brain. Use of the Trendelenburg position at operation may prevent the passage of air into the aorta if air has been trapped in the left ventricle.

Laboratory and Clinical Experience with the Bubble Oxygenator

Our experience with successful perfusions lasting up to one hour using the plastic oxygenator in the laboratory[12] assured us that it could be used safely clinically. Consecutive survivals in twenty dogs encouraged us to attempt the repair of human septal defects.

We have treated three patients with uncomplicated intra-atrial septal defects of the septum secundum type. No complications or ill effects have been attributable to the oxygenator. Two patients have had successful repair of atrial defects and their recovery has been uncomplicated. The other patient did not survive because of a technical error in placement of the superior vena cava catheter. As the atrium was being opened the catheter slipped out of the vena cava and a fatal cerebral air embolus occurred.

At present, we are endeavoring to improve the efficiency of the pump oxygenator to afford greater length of safe operating time with minimal aberration in the patients physiology. We have found that controlling asystole with a solution of potassium citrate and magnesium sulfate[13] is very successful in the laboratory for lesions in the ventricular septum and lesions of the aortic valve. One successful clinical case in whom ventricular septal defect was closed during controlled asystole for twenty minutes encourages our further efforts with this method.

Summary

The brief history of cardiac by-pass has been dominated by the desire to make the procedure as uncomplicated as possible. The bubble oxygenator is a simple extracorporeal shunt. The plastic oxygenator and Sigmamotor pump now in use at the University of Michigan meet the requirements of simple construction and ease of operation. This oxygenator will provide at least forty minutes of safe operating time to the surgeon performing open cardiotomy.

The satisfactory use of this bubble oxygenator depends upon a large blood reservoir and the recognition of the time limits beyond which damage to blood elements occur. Although mechanical failure of the oxygenator is eliminated by its simplified construction, problems related to tubing, connectors and vascular catheters must be constantly avoided. Air bubbles and fibrin emboli resulting from the bubbling of oxygen through blood are the chief dangers to the patient when the bubble type oxygenator is used. The large blood reservoir is the important barrier which prevents brain injury from embolic fibrin or air.

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(Continued on Page 70)

Mechanical Respiration during Anesthesia for Surgery

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THE FOREMOST problem confronting the anesthesiologist, today, is the maintenance of normal respiratory physiology in the anesthetized patient.

Some degree of pulmonary hypoventilation is the consequence of practically every anesthesia regardless of the agent or the technique used to produce it. Add to this, the infringement on the patient's respiration stemming from the exigency of surgery itself or the handicap of complicating cardio-respiratory disease, and the problem is readily apparent.

It is our opinion that, except for the relatively few cases of overdosage, drug idiosyncrasy and reflex phenomena, cardiac arrest during anesthesia stems primarily from extreme deviations of respiratory physiology.

The number of separate factors contributing to such deviations makes for an impressive list. The first purely anesthetic factor to be considered is premedication, because anesthesia actually starts here. Barbiturates and narcotics are the chief depressants as premedicants, and it is their injudicious use which results in difficulties. The most common complication is illustrated in the patient who arrives at the operating room markedly depressed, hypotensive and hypopneic. In the normal healthy patient this handicap may mean nothing, but in the poor-risk patient, it may be quite serious. As shown by Etsten,[1] premedication itself can produce CO_2 retention and hypoxemia, before the initiation of anesthesia.

Beecher[2] has emphatically stated that there is no place for narcotics in premedication, unless the patient is in pain. Perhaps the answer to more physiologic premedication will be found in the category of the recently developed mood drugs, the so-called tranquilizers.

General anesthesia adds a large share to the total problem of hypoventilation. All of the general anesthetic agents produce respiratory depression at surgical levels of anesthesia and the depression increases proprotionately with depth. Those who argue that such depth of anesthesia with its concomitant respiratory depression is no longer necessary in this era of muscle relaxants, are overlooking the fact that surgical relaxation in light general anesthesia under curarization is indistinguishable from the deepest planes of pure general anesthesia. The intercostal paralysis—which is a pharmacologic effect of deep ether anesthesia—is mimicked exactly by the direct intercostal paralysis of the curarizing agents. The same mechanisms come into play to depress minute volume, and to produce hypoxia and CO_2 retention.

A vague realization of these facts by some surgeons has resulted in the erroneous conclusion that spinal anesthesia should be used for all surgery where profound relaxation is mandatory. They forget, however, that spinal anesthesia to the nipple line, the 4th thoracic dermatome, is the necessary level for upper abdominal surgery.[3] At this level a large per centage of the accessory muscles of respiration will be eliminated. It is not unusual to see patients with high spinal anesthesia show sharp, jerky diaphragmatic respirations and a tracheal tug—indications of respiratory insufficiency. A patient with such a handicap placed on his ventilatory abilities can, with the addition of hypotension, become quite hypoxic.

The demands of surgery often contribute as much to the problem of ventilation during anesthesia as the anesthesia itself. Foremost among these demands are those encountered during thoracotomy. For in this procedure, the respiratory mechanism suffers a derangement which could prove fatal, if it were not for the supportive measures of the anesthesiologist. Pulmonary collapse, mediastinal shift and reflex activity, all contribute to progressive hypoxia and CO_2 retention on a scale which has only recently become recognized and appreciated.

Besides thoracotomy, other purely surgical con-

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siderations influence ventilation. The restriction of diaphragmatic excursion by packs and retractors in the upper abdomen is a considerable item when we remember that in deep anesthesia the diaphragm may be the only respiratory muscle in action. Examples of other restrictive factors on ventilation, are: (a) The steep Trendelenburg position which pushes the abdominal contents up against the diaphragm, and (b) the nephrectomy position, which depends on a broken table and an elevated kidney rest.[4]

Finally, in considering factors influencing ventilation, we must not ignore the patient's disease, which may or may not be the reason for the surgery considered.

Primary pulmonary pathology, for example, tuberculosis, bronchiectasis, carcinoma—all can produce alterations in normal respiratory physiology. Also cardiac disease with resultant congestive failure, pulmonary hypertension et cetera, can effect serious changes in a patient's ventilatory efforts. Yet pulmonary and cardiac surgery are increasing while the old barriers of anesthesia-risk are disappearing. The fundamental basis of anesthesia and resuscitation is still the maintenance of an intact and adequate circulatory and respiratory system. Any degree of deviation from adequacy will multiply the anesthesiologist's job of maintaining vital function, and none is more immediately vital than an exchange of respiratory gases in concentrations approaching normal, or better than normal, levels.

The approach to the problem of ventilation by anesthesiologists until recently has revolved about two general methods. In one, oxygenation was insured by providing high O_2 tensions in the artificial atmospheres they supplied the patient. If this proved inadequate, a second general method was called upon. The patient's respirations were assisted or replaced with artificial respiration. The latter methods are possible by squeezing the reservoir bag of the anesthesia machine.[5]

To adequately take over a patient's respirations, one or more conditions must be present, and these are usually contingent on a state of depressed respiratory activity.

This paper represents experience with 233 major surgical procedures, primarily thoracic, on seriously ill and poor-risk patients, in which a mechanical respirator[6] has been used to substitute for manual compression of the reservoir bag by the anesthesiologist.

Several types of this apparatus are available but the constant principle of all of them is a mechanically activated bellows, substituted for the reservoir bag of the anesthesia machine. In essence, the bellows inflates the lung to a predetermined and adjustable pressure and then deflates the lung actively by producing a negative pressure which is equally measurable. A method of varying the rate of respiration is also incorporated.

Up to now, other techniques for controlling respiration have had the disadvantage of either delivering positive pressure only or of maintaining pressure in the respiratory tree of above-normal levels. Continued elevated pressure in the respiratory tree can produce serious cardiovascular disturbances—primarily, decreased cardiac return, diminished cardiac output and hypotension.[7]

In evaluating our experience with this apparatus, we feel that for the first time we are able to fully employ recent concepts of polypharmacy as an approach to analgesia rather than anesthesia in surgery. In short, the guarantee of adequate ventilation has perfected anesthetic care which, up to now, has been impeded by this one all-important consideration.

In this group of patients the ages have ranged from nine to eighty-nine years with the median range being the forty to forty-nine-year group.

As to type of operation, sixty-nine per cent have been thoracic procedures, ranging from surgery of the lung to cardiac operations, for example, excision coarctation aorta, resection patent ductus arteriosus, mitral commissurotomies, pulmonary valvulotomy, et cetera. Also there have been those procedures utilizing the combined thoro-abdominal approach.

TYPE OF OPERATION

Chest		162
A. Pulmonary surgery	83	
B. Cardiac surgery	63	
C. Other	16	
Abdominal		71

All patients have been classified according to the grading system of the American Society of Anesthesiologists—this schedule assesses the preoperative physical status of the patient.[8]

They are as follows:

Category 1	65
2	92
3	50
4	4
5	12
6	10
7	0

We think that the general course of these cases has been more stable with the use of this machine. We have used less in amount of anesthetic drugs. As a consequence we have had experiences comparable to those of Artusio.[9] That is, patients respond to simple commands such as "open your eyes," during the course of a major surgical procedure. Yet these patients are analgesic and amnesic as to their surgical experience.

There has been a marked reduction in the incidence of hypotensive crises. These were quite common in the past, especially in patients undergoing cardiac surgery. Hypotension is quite a serious complication, and its near elimination from anesthetic causes has been most welcome.

There is also less severe change in the metabolic state of patients receiving this type of anesthesia; respiratory and metabolic acidosis does not occur. As a result, fluid and electroyte balance is maintained more easily. In general, even our poorest-risk patients, who have had major surgical procedures are awake and capable of answering questions at the end of surgery.

This has been a marked asset in the postoperative period. These patients are capable of quickly beginning a postsurgical course of active coughing, deep breathing exercises, and early ambulation.

This has helped prevent respiratory and vascular complications.

Having a patient on the ventilator may seem to simplify the problem, but we find that more attention has to be paid to the patient and to the equipment. The equipment is only as good as the operator. Constant surveillance has to be maintained.

To illustrate, in one case, a coupling between the patient and the machine separated without immediate recognition of this accident. The patient became cyanotic, showed signs of severe hypoxia, yet because the machine was still working along and making its characteristic sounds, it was thought that some other factor was responsible for the complication rather than the equipment. Fortunately, a quick check revealed the trouble, it was corrected and no harm resulted.

Another disadvantage of the ventilator is that there is no means of ascertaining exactly the tidal volume in cubic centimeters that is being delivered to the patient. However, neither does one know quantitative volume when manually compressing the rebreathing bag. It is a matter of clinical observation and judgment. It would be highly desirable to incorporate into the apparatus a meter to indicate respiratory volumes. As stated before, the pressures at which the gases are delivered and removed from the respiratory tree, are predetermined and adjustable. Both positive and negative pressures have a range up to 25 cm H_2O. However, with one patient, suffering a severe chronic asthmatic condition with marked emphysema and pulmonary fibrosis, the machine could not deliver adequate pressure to inflate the patient's lungs.

Only by tremendous manual compression of the rebreathing bag, could the patient be ventilated with any degree of sufficiency.

Discussion of One Death

In this series there has been one death attributable to anesthesia. This was a forty-plus-year-old man with a history of obstructing duodenal ulcer. He was to undergo gastric resection. Preoperative evaluation of the patient revealed him to be in good health with no other serious complaints or complicating disease. He was prepared for surgery. Preoperative medication consisted of Nembutal,® 100 mgm ninety minutes before surgery; Demerol® 100 mgm; atropine 0.6 mgm, one hour before surgery. The anesthetic was to be spinal, supplemented with Pentothal® and N_2O, and O_2. A prespinal dose of ephedrine (50 mgm) was given approximately twenty minutes before lumbar puncture. Spinal anesthesia was performed with Pontocaine® and dextrose 16 mgm plus 0.2 cc adrenalin, a level to D-4 established and then a small sleep dose of Pentothal was administered. Following this the patient was put on N_2O and O_2, 4 liter/min. flow of each.

Very shortly after this, a drop in blood pressure to 60/40 occurred. This was treated with an intravenous Neosynephrine® drip (10 mgm/500 cc 5 per cent D/W). From this point on, the patient's blood pressure fluctuated greatly and was difficult to maintain on an even plane. Without the intravenous pressor the blood pressure would immediately fall to very low levels. As an additional factor, it was determined that the patient was not ventilating adequately, a situation resulting from a combination of factors—the high spinal, the amount of pentothal necessary to keep the patient asleep, and the presence of retractors

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and sponges in the abdomen. At this point the patient was intubated and placed on the ventilator. Difficulty was still encountered in maintaining a level blood pressure but no other problems were encountered and surgery proceeded uneventfully. Three units of blood were given during surgery which was felt to be adequate replacement. As the last skin sutures were being placed, there was a sudden cessation of pulse with no blood pressure obtainable, pupils became widely dilated and a diagnosis of cardiac arrest made. Immediate thoracotomy was undertaken. The heart was in asystole, and all efforts at resuscitation were fruitless. Autopsy showed only as a significant factor—marked coronary artery atherosclerosis with narrowing. Microscopic examination revealed minimal myocardial fibrosis.

Discussion

Because of the breath and scope of modern surgery, with operations on patients of both age-extremes, of surgical procedures of great inherent stress and severity, with patients presented as candidates for surgery who as recently as ten years ago would have been refused entrance to an operating theater, anesthesia as a medical specialty has become a challenge.

One of the most recent and important answers to this challenge has been the advent of controlled mechanical respiration during anesthesia. To us, this has been a definite adjunct in the anesthetic management of our patients. We think that this mechanical respirator has such merit, that we are reluctant to do thoracic surgery without its employment.

These merits are:

1. Maintenance of normal respiratory physiology.
2. Marked reduction in total requirement of anesthetic agent.
3. Decreased incidence of hypotension.
4. Early awakening and recovery.
5. More rapid ambulation with prevention of postoperative complications.

Summary

The concept of analgesia in surgery to supersede anesthesia is a logical projection of all clinical and investigative experience to date.[10] The protoplasmic toxic manifestations of heavy dosage necessary to produce surgical anesthesia with one or two agents are well known.

The conclusion, then, is that a method employing minimal dosages and insuring a normal exchange of respiratory gases should prove to be a welcome addition in the anesthesiologist's armamentarium.

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DEVELOPMENT OF A SATISFACTORY PUMP OXYGENATOR

(Continued from Page 66)

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The Problem of Psychiatric Symptom Formation

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A DISCUSSION of symptom formation in psychiatry at our present level of sophistication involves an exceedingly complex series of hypotheses and formulations. This has been well exemplified by the fact that psychiatry has been in difficulties since its inception as a discipline within the medical sciences when it approached nosology. Indeed, the most recent summaries of a committee of the American Psychiatric Association tended to point up the complexities and difficulties inherent in this area.[1] In order to understand symptom formation in relation to any aspect of medicine, it is necessary, therefore, to have certain hypotheses regarding health and disease.

In recent years within psychiatry, and especially within the field of psychosomatic medicine, attempts at formulation of such hypotheses have been made. Three names immediately come to mind—Grinker, Engel, and Karl Menninger—as the most recent contributors in this area. As in all branches of science, the most recent contributor is but one in a long line of workers who have attempted to ask the questions and supply the answers. Merely to list such workers would require more space and time than is available. Therefore, in this paper I shall restrict myself only to certain writers whose names are familiar, utilizing their work as paradigms for the attempts to understand the problems as they were formulated in their time.

Psychiatry is a branch of medicine, and as a branch of medicine its broadest base is biologic. Therefore, any attempt to understand psychic symptom formation must essentially relate to the understanding of symptom formation in any other of the areas of medicine. Since there are fundamental biologic laws, any explanation of symptom formation regardless of the nature of the symptom must be within the sphere of biology. Therefore, from this point of view fever and phobia must qualitatively serve a similar biologic function in relation to the adaptation of the organism.

Grinker in his recent writings, particularly in the volumes on "Psychosomatic Research"[2] and the "Psychosomatic Casebook,"[3] has presented hypotheses in the area of psychosomatic medicine involving a field concept. Without entering into all the details of his presentation, it may be sufficient to state that this field theory "applied to psychosomatic science is a dynamic concept borrowed from physics for the consideration of organization of parts and wholes. This organization although constantly in the proces of change has a stability in its 'part-whole' relationships. Viewed during a short time segment along a spatial dimension, it appears as a structure. Viewed as a process in time during change, it has a function. Thus the living organization is a structure-function of which special aspects become accentuated depending on the position of the observer."[3] He emphasized that the parts are not separate, independent and self-acting entities, but are continually acting in accordance with their own "structure-function, reacting or straining under stress and interacting with other parts of the whole. Through these processes the parts of an organization maintain the whole, not as a sum, but through integrated transactions."[3] The psychosomatic field then becomes a continuum "in which there is a tendency through transactions to maintain equilibrium, orderliness or steady state."[3] He maintains that one can view the whole field as a "transaction among somatic, psychological and cultural processes." He emphasizes the genetic approach involving all aspects of the field, and maintains that the function of the organism at any given time depends upon its whole previous history, which includes also its hereditary and constitutional aspects and involves its total previous responses in this continuum. In other words, one can only understand any immediate reaction of the organism, which would include symptom formation, in the light of its total history. This brief summary does less than justice to Grinker's excellent formulation, but since I

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wish to use it here only as a background, I can only recommend the reader to the original writings.

The volume, "Mid-Century Psychiatry" edited by Grinker,[4] presents a series of papers read at the opening in 1951 of the Institute for Psychosomatic and Psychiatric Research and Training of the Michael Reese Hospital. Engel[5] in his brilliant paper, entitled "Homeostasis, Behavioral Adjustment and the Concept of Health and Disease," has presented perhaps the most concise and well thought out organismic point of view which involves the organism's phylogenesis, ontogenesis, biologic, psychologic, and social aspects. He presents a point of view which is truly organismic and biologic in the widest sense of the term, since within the structure and function of any given organism the same laws are applicable. The organism and its relationship to its environment is in a constant state of flux which, nevertheless, involves a continuous series of processes utilizing all aspects of its functioning and in an inter-related series of procedures aimed at the establishing of an equilibrium.

The mutually interchangeable biologic and psychologic devices are phylogenetically and ontogenetically determined. The past of the individual, both in phylogenesis and ontogenesis, provides the mental apparatus with processes for expression and defenses which may be somatic systems. "The behavior of the organ or system so used is limited by its structure and function." Thus organs and systems may respond to widely diverse stimuli, whether somatic or psychic, in a similar way.

He elaborates further the extremely complex inter-relationship of the variables involved, particularly in the areas of biologic, psychologic, and sociologic adjustment. Here again, one should emphasize the relative injustice to the author in attempting briefly to summarize his point of view.

Karl A. Menninger has recently formulated a point of view which is of great interest and value. Essentially his thesis is that the principle of homeostatis can be applied to psychologic phenomena, that the functions of the ego can be viewed as "those of a homeostatic effector." In order to maintain the integration of the organism, the ego needs to improvise many adaptive expedients. The prevention of threatening disintegrative processes is handled by the ego with a series of emergency regulatory devices. His thesis is summarized as follows:

> "I believe that this conceptualization of the ego's regulatory function provides us with a broader frame of reference for understanding mental illness and will enable us to discard some of our vague, many-faceted, traditional terms in exchange for more definite and precise designations of process and stage. It also helps us to align our psychoanalytic concepts with general organismic-biologic theory."[6]

My own point of view is somewhat of a combination of the foregoing positions insofar as I can understand them with certain, perhaps minor, variations. I look upon the organism from a number of perspectives. Each organism, in this instance man, has a long phylogenetic and evolutionary history. This is specifically related to his genus and species which allows for certain potentials and sets certain limitations on the functional relationship between the organism and his environment. The ontogenesis of the individual is of tremendous significance since, within the potentials and limitations of the genus and species, the organism develops in a progressive and integrated way with each system (digestive, cardiovascular, central nervous, autonomic, psychic) shunting in after functional maturation to take over that role which its structure and function calls for in the total functioning of the organism. From the very beginning at the level of sperm and ovum, the processes have an adaptive equilibrium between organism and environment, each playing its essential role which involves the ultimate for survival. With the development and integration of the various systems, of which the psyche is one, the systems relate to each other in a kind of syncytium, which means that no activity within one system can be isolated and unrelated to the total integrative, homeostatic, if you will, function of the organism. Each system's function is delimited and potentiated by its inherent structure and modalities available to it. Therefore, one can say that the blood system can only function with the capacities of a blood system. The cardiovascular system functions only within the capacities of its structure, and the psychic system functions within its capacities in terms of the modalities and processes available to it.

It is necessary to re-emphasize that structure and function are intimately related, but that the part is never greater than the whole, and the

whole is always greater than the sum of its parts, only in the sense that the whole functions in an integrated fashion and in a way which is not possible for any one of its individual parts. Flight or fight is an organismic reaction and not a part reaction. Throughout the intra-uterine development of the individual the embryo and fetus are subject to environmental forces, and the continual need for the maintenance of homeostasis is biologically necessary. In many given instances where the stimuli provoke a reaction which requires an adaptation beyond the borders of the system or organism's capacity, a disruption results which may or may not be reversible and which might be called a disease process.

As psychiatrists, we are interested in the question as to when the psychic system begins to develop in the organism. There is a good deal of evidence that points to an intra-uterine development of this system. The work of Hooker[7] and Coghill points in that direction. This question is of more than academic interest, since some hypotheses would indicate that ego function, particularly in the sphere of the autonomic ego, begins prenatally.

With the advent of birth, the human organism is subject to a series of stimuli and experiences of tremendous significance for its future growth and development. The role of maturation in relation to function throughout is of prime significance. Throughout the organism's functioning, one is constantly dealing with a series of variables relating to each other in such a way that the change within any one variable predicates the change in the relationship of all variables to each other with the resultant change in the overall organismic reaction.

Emphasis has been placed on the structure-function of the systems within the organism. It has been stated that the structure of the system delimits its function and that the modalities and processes available to any system will determine the functioning of that system. I should like to carry this thought further in regard to the psyche.

Adaptive processes as related to the organism, both in its internal economy and its relationship to the environment, have long been known and conceptualized in various ways in the biologic sciences. The "milieu interieur" concept of Claude Bernard (1878) perhaps was the first summarized presentation in modern times. The work of Walter B. Cannon which began in the early part of this century and which demonstrated the efforts of living organisms to maintain a steady state both in relation to their internal and external environment was an outstanding contribution in this field. As is well known, Cannon suggested the term homeostasis for these states, since "the constant conditions which are maintained in the body might be termed *equilibria*. That word, however, has come to have fairly exact meaning as applied to relatively simple physico-chemical states, in closed systems, where known forces are balanced." He further stated that "The coordinated physiological processes which maintain most of the steady states in the organism are so complex and so peculiar to living beings—involving, as they may, the brain and nerves, the heart, lungs, kidneys and spleen, all working cooperatively—that I have suggested a special designation for these states, *homeostasis*. The word does not imply something set and imobile, a stagnation. It means a condition—a condition which may vary but which is relatively constant."[8]

The acceptance of a conceptual frame of reference which involves the total organism as a syncytium of open-ended systems, which includes the psychic system as a constantly functioning, interrelated, integrative series of processes, does away with any need for dichotomization between psyche and soma. It enables one to formulate the problem of symptom formation in that area of human functioning that comes under the special observation of psychiatry. Reference has been made to the fact that the functions of each system are delimited by the modalities and processes available to that system. This is true of the psychic system. In addition to the intrasystemic functions of the psyche, there is another extraordinarily significant and important role that this system plays, in that it serves as an integrator and coordinator and stimulus source in relation to the other systems. In many ways, it is the system most closely related to the environment, and in that sense the most plastic.

In the history of medicine certain discoveries are of fundamental importance and serve to clarify previously unclear areas. In addition, the way is opened for reformulation of previous knowledge and for breaking ground for new knowledge. The work of Sigmund Freud was of this fundamental character. It would be difficult if not impossible to present even a summary of a summary of the discoveries, hypotheses, theories,

and concepts which make up modern psychoanalytic psychology. Nevertheless, it will be necessary to present, even though in an extremely oversimplified way, the development of this psychology.

It is the uniqueness of psychoanalytic psychology and its essential differences from previously formulated systems of psychology that permits the integration of the psyche into the total organism. It is only in the light of our understanding of psychoanalysis and its unique contribution that it is possible to uphold a thesis such as mine. In a previous publication on "Problems of Therapy,"[9] some aspects of the problem were discussed.

Freud's basic position has always been a biologic one which involved a perspective of the total organismic functioning. He chose to work in the area of psychology because that limitation seemed to offer him the greatest opportunity for the evolution of his ideas. Sight must never be lost, however, of the basic fact that even in his self-designated speculations, he always attempted to remain within the framework of the biologic sciences.

Psychonalysis as a system of psychology has various aspects—the dynamic, genetic, topographic, structural, and economic. Each one of these aspects has a developmental history within the conceptual framework of psychoanalysis. Beginning essentially with a two-system aspect, the Unconscious and Conscious, and the relationship between these two systems, there was recognized the interplay of dynamic forces. The genetic aspect involved both hypothetical phylogenesis and ontogenesis. Within this framework it was recognized that there was a basic genetic relationship within the development of the individual. This has become a fundamental part of psychoanalytic thinking. In addition, from the very beginning, analysis dealt with energy systems in terms of stimulus and discharge, and the economic problem of energy distribution was related to the instincts.

A knowledge of the modalities and processes available within the psychic system is as essential as similar knowledge in relation to any other system within the organism. For instance, it is of special importance to emphasize the special sense in which psychoanalysis uses the term "unconscious," particularly in the sense of the system "Unconscious." The laws of primary process which exist in the Unconscious make for its uniqueness, and differentiate the Unconscious of Freud from any other concept of the unconscious. For instance, the fact that in the Unconscious there is no negation, that it is characterized by timelessness, that it is subject to the pleasure principle, that it is exempt from mutual contradiction, that it is not related to reality, that there can be a substitution of psychic for external reality, that there is mobility and displacement permits of an adaptation which leads to symptom formation in the total functioning of the organism. The above may be likened to the physiologic modalities of the central nervous system or the hematopoietic system.

There are available certain mechanisms of defense which, within the psychic system, are of the same order as the processes available to the organism in responding to such diverse situations as changes in oxygen, tension, or an irritant leading to inflammation. Just to name these mechanisms is to become aware how deeply incorporated they have become in our psychiatric thinking —repression, regression, reaction-formation, isolation, undoing, projection, introjection, turning against self, reversal, sublimation or displacement of instinctual aims.[10]

One of Freud's earliest contributions was a demonstration that neurotic symptoms were not haphazard, meaningless phenomena but were especially related to the total experience of the individual; that they had a complex but definable significance in the workings of the psychic apparatus; and that they served as a compromise formation in the solution of a conflict. Another important postulate in analysis has been the relationship of specific phases of development in terms of libido theory and the gradual evolution of the ego and superego systems to the type of maturation and development which enter into personality organization and the specific relationships of certain character traits and neurotic symptoms to specific phases of development.

As I have stated in another context, psycshoanalysis is biologically based and body bound.[11] Some pseudoscientific quarrels have arisen between different groups primarily because overemphasis has been placed by one or the other group on different aspects of the ecologic interaction pattern. Perhaps the statement that culture channels instinct might express the formulation best.

The problem of symptom formation and its nosologic concomitant is as old as medicine (Hip-

pocrates). All systems in a biologic organism and all reactions of that organism must follow fundamental biologic laws. As stated above, the mechanisms through which these laws function depend, of course, on the modalities and processes available to the organism and the organism's systems. This concept is fundamental, and there are no exceptions to the rule. What appear to be exceptions turn out to be matters related to our ignorance. One might use what happens in infections as a paradigm rather than an analogue of the point of view relating to symptom formation expressed above.

Harrell in the chapter on "Factors Affecting Infections" in Sodeman's "Pathologic Physiology" states the matter rather well, and I take the liberty of quoting him.

> "Infections are the result of a constantly changing set of factors. People are continuously exposed to agents of disease, either directly from the environment or indirectly from some reservoir of infection, often through the mediation of a vector. The severity of any particular infectious disease varies with three factors: (a) the number of invading organisms, (b) the virulence of the organism and (c) the resistance of the host. The interrelationship of these factors may be expressed as follows:
>
> $$\frac{\text{Number} \times \text{virulence}}{\text{Resistance}} = \text{Severity."}^{12}$$

It obviously is too difficult, complex, and time consuming a job to trace through the mechanisms of all symptom formation. If one accepts an organismic point of view, it follows that any change leading toward a new type of equilibrium cannot be restricted to any single system. Therefore, symptoms and signs observed either objectively or subjectively within the psychic system are but the overt manifestations of a total adaptation going on within the organism. A subjective feeling of shame manifests itself in many ways and in many systems, from a flushing of the face to an increase or decrease in the pulse rate. Darwin's "Expression of the Emotions in Man and Animals"[13] documents this beautifully, and innumerable poets and scientists have demonstrated its truth. It may be trite to draw attention again to the fact that the symptoms and signs that we call disease, as for instance in a pneumonia, really represent a focusing on only one aspect of the total reaction of the organism which takes place in pneumonia. This has implications for nosology in psychiatry that I hope to have an opportunity to discuss at some future time.

By way of illustration and following Freud in "Inhibition, Symptom and Anxiety," illustrations of symptom formation in phobia, hysteria, obsessional neurosis, and schizophrenia may be used as examples of the individual's adaptation through the utilization of the modalities and processes available to him, particularly within the psychic system. It is extremely difficult to point to even a single paper of Freud's which does not in some way or other concern itself with the problem of symptom formation. In this classic monograph which was first published in German in 1926 and of which two English translations exist, one by Henry Bunker[14] published in this country, and one by Alix Strachey[15] published in England, is presented Freud's most considered formulations to that time.

Freud was very careful to emphasize the complexities involved and to bring to the attention of the reader the relative sparsity of knowledge available. He attempted a differentiation between an inhibition of function and symptom formation, and made numerous illustrations of both. At times, however, he pointed out that what might be considered an inhibition in one context could readily be considered a symptom in another. Broadly speaking, inhibition involved a functional limitation of the ego, whereas symptoms denoted pathologic processes. For purpose of discussion and comparative study, he selected sexual function, eating, locomotion, and occupational work.

At the core of psychoanalytic thinking in relation to mental functioning, particularly symptom formation, lies the problem of anxiety. Originally, Freud's formulation of anxiety was essentially a physiologic one in the sense that he postulated that any affect which was repressed could be turned into anxiety. Later this concept was changed to what is essenitally a psychologic formulation, namely, that anxiety was a subjective mental signal of an internal danger situation. The full implications of this change have as yet not been fully assimilated.

In attempting to differentiate between anxiety and other affects, Freud stated that anxiety was a subjective feeling related to dread which was accompanied by motor manifestations. Throughout psychoanalytic literature and in the literature of dynamic psychiatry, one still speaks of symptoms as binding anxiety, whereas in reality it seems to me that the feeling of anxiety and the concomitant somatic manifestations are not necessari-

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pocrates). All systems in a biologic organism and all reactions of that organism must follow fundamental biologic laws. As stated above, the mechanisms through which these laws function depend, of course, on the modalities and processes available to the organism and the organism's systems. This concept is fundamental, and there are no exceptions to the rule. What appear to be exceptions turn out to be matters related to our ignorance. One might use what happens in infections as a paradigm rather than an analogue of the point of view relating to symptom formation expressed above.

Harrell in the chapter on "Factors Affecting Infections" in Sodeman's "Pathologic Physiology" states the matter rather well, and I take the liberty of quoting him.

> "Infections are the result of a constantly changing set of factors. People are continuously exposed to agents of disease, either directly from the environment or indirectly from some reservoir of infection, often through the mediation of a vector. The severity of any particular infectious disease varies with three factors: (a) the number of invading organisms, (b) the virulence of the organism and (c) the resistance of the host. The interrelationship of these factors may be expressed as follows:
>
> $$\frac{\text{Number} \times \text{virulence}}{\text{Resistance}} = \text{Severity."}^{12}$$

It obviously is too difficult, complex, and time consuming a job to trace through the mechanisms of all symptom formation. If one accepts an organismic point of view, it follows that any change leading toward a new type of equilibrium cannot be restricted to any single system. Therefore, symptoms and signs observed either objectively or subjectively within the psychic system are but the overt manifestations of a total adaptation going on within the organism. A subjective feeling of shame manifests itself in many ways and in many systems, from a flushing of the face to an increase or decrease in the pulse rate. Darwin's "Expression of the Emotions in Man and Animals"[13] documents this beautifully, and innumerable poets and scientists have demonstrated its truth. It may be trite to draw attention again to the fact that the symptoms and signs that we call disease, as for instance in a pneumonia, really represent a focusing on only one aspect of the total reaction of the organism which takes place in pneumonia. This has implications for nosology in psychiatry that I hope to have an opportunity to discuss at some future time.

By way of illustration and following Freud in "Inhibition, Symptom and Anxiety," illustrations of symptom formation in phobia, hysteria, obsessional neurosis, and schizophrenia may be used as examples of the individual's adaptation through the utilization of the modalities and processes available to him, particularly within the psychic system. It is extremely difficult to point to even a single paper of Freud's which does not in some way or other concern itself with the problem of symptom formation. In this classic monograph which was first published in German in 1926 and of which two English translations exist, one by Henry Bunker[14] published in this country, and one by Alix Strachey[15] published in England, is presented Freud's most considered formulations to that time.

Freud was very careful to emphasize the complexities involved and to bring to the attention of the reader the relative sparsity of knowledge available. He attempted a differentiation between an inhibition of function and symptom formation, and made numerous illustrations of both. At times, however, he pointed out that what might be considered an inhibition in one context could readily be considered a symptom in another. Broadly speaking, inhibition involved a functional limitation of the ego, whereas symptoms denoted pathologic processes. For purpose of discussion and comparative study, he selected sexual function, eating, locomotion, and occupational work.

At the core of psychoanalytic thinking in relation to mental functioning, particularly symptom formation, lies the problem of anxiety. Originally, Freud's formulation of anxiety was essentially a physiologic one in the sense that he postulated that any affect which was repressed could be turned into anxiety. Later this concept was changed to what is essenitally a psychologic formulation, namely, that anxiety was a subjective mental signal of an internal danger situation. The full implications of this change have as yet not been fully assimilated.

In attempting to differentiate between anxiety and other affects, Freud stated that anxiety was a subjective feeling related to dread which was accompanied by motor manifestations. Throughout psychoanalytic literature and in the literature of dynamic psychiatry, one still speaks of symptoms as binding anxiety, whereas in reality it seems to me that the feeling of anxiety and the concomitant somatic manifestations are not necessari-

ly in a vertical relationship. This, in some sense, is implied by the various discussions about anxiety.

Freud has sought for the prototype of the original danger situations and anxiety manifestations in the birth experience. In terms of organismic adaptation, the fight or flight reaction to danger, one might very well think of the somatic manifestations as a cotemporal reaction of the individual somatically to adapt to the danger signalled by anxiety in either a flight or fight reaction. There are many symptomatic situations in which this coexistent relationship is quite clear. In the phobia, an avoidance of the danger place results in a disappearance of anxiety. Of course, one must take into account the role of overdetermination, the compromise nature of every symptom in terms of the striving and satisfaction of every instinctual impulse, the role of the defensive maneuvers, the secondary libidinization of the defense mechanisms themselves, and a host of other known and complicating factors. And to be aware of the fact that any oversimplification can never tell the total story. And again in the phobic reaction, the danger place may become ever-widened, that is, an unconscious source of gratification, so that the safety place protected by the counterphobic attitude becomes more restricted.

I should like to speculate that the somatic manifestations of increased heart rate, respiratory movements, gastrointestinal manifestations, et cetera, that are seen in an anxiety attack are indeed related to the birth situation. However, all of these are necessarily adaptive to the new environment. Without respiration the neonate cannot survive. This would fit much more closely with the organismic point of view. Freud, himself, of course recognized this at various times and differentiated between the danger signal and the danger situation. In conversion hysteria it appears that a conflict situation in an individual who has reached the phallic level of development at the time of the oedipus complex and in relation to its implications resolves the conflict by the utilization of the mechanism of repression as a defensive maneuver.

Perhaps the most dramatic difference between Kraepelin and Bleuler is not in the attempt at classification as it is in the attempt to understand. Bleuler's class monograph,[16] his division of the symptoms of schizophrenia into primary and secondary based on the hypothesis of the schizophrenias as an organic disease responsible for the primary symptoms and the secondary symptoms as attempts at restitution, was the academic acknowledgment of the validity of Freud's hypothesis. Mention should be made of Jung's "Psychology of Dementia Praecox"[17] published in 1906.

I should like to differentiate for the purposes of my thesis between the meaning of the content of a symptom or sign and its meaning in the total biologic functioning of the organism. Psychoanalysts to a great extent following along Freud's path of choice made excellent contributions to the knowledge of the meaning of content and form without necessarily taking the essential conceptual step of placing the symptoms and the signs manifested within the psychic system in their true perspective. If the implications are followed to their logical conclusions, it becomes possible not only to understand the psychologic significance of psychic symptoms but also their biologic significance. Freud's work on the dream may be used as an illustration of the difference between the understanding of the content and the meaning of the symptom. To Freud the structure of the dream was like the structure of a symptom. In dream analysis one can understand the unconscious wish which is fulfilled from the analysis of the content within the proper setting of the psychoanalytic technique. The dream as a dream, as Freud has pointed out, has the function of guarding sleep so that the dreamer may continue to sleep rather than be awakened by the stimulus.

There is no need to deal with the psyche as an extraterritorial state. The totality of the organism and its adaptation and adeptedness in the sense of Paul Weiss[18] can be placed in a frame of reference which is truly biologic and one may understand fever and phobia as within their appropriate level of biologic homeostasis. Phylogenesis, ontogenesis, and ecology, each with its proper weight and each unique for the particular individual involved remains the basis for the understanding of the functioning of the individual in health and disease.

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(Continued on Page 86)

Michigan Heart Association

Striking at the heart of a disease—through research—is the praiseworthy technique of the Michigan Heart Association. We wish that more voluntary organizations were as dedicated to solving basic scientific unknowns.

Admittedly, it is sometimes necessary for the health organization (as well as the doctor of medicine) to consider the symptom instead of the cause. But this is purely a short-term measure and is necessary only until further fruits of scientific research are borne.

The feeling of the medical profession toward the Michigan Heart Association is best indicated, I believe, by the close co-operation that has continuously existed between the two groups. This co-operation is a direct result of the Association's research approach to the overall heart problem.

Working together, the practicing physician, the researcher, and the Heart Association can surpass their previous efforts and eventually ring down heart disease as the nation's number one killer.

Geo. W. Slagle.

President, Michigan State Medical Society

President's Message

Editorial

THE CHALLENGE OF HEART DISEASE

In an editorial in the first issue of *Challenge*, the newly published newsletter of the Michigan Heart Association, M. S. Chambers, M.D., Flint, the Association's President, stressed the educational services made available to Michigan physicians.

"More and more physicians," he says, "are being reached through scientific exhibits, publications and meetings. A larger segment of the general public is also being reached through the press, radio and TV, as well as through exhibits, talks and publications. The organizing of Heart Units throughout the State will tend to accelerate this entire educational program."

Dr. Chambers reiterated that, although approximately 50 per cent of all the Michigan Heart Association's funds have gone into scientific heart research, the Association is stepping up rapidly the process of bringing the results of this research to the medical profession and to the public.

He says that an interested medical profession and an informed public can do a great deal to help promote the scientific investigations and other activities of the Association which will help to decrease the tragic and unnecessary toll taken by heart disease.

"By becoming a working member of the Michigan Heart Association," Dr. Chambers points out, "*You* can help meet the *challenge* of heart disease."

EDITOR'S NOTE

In the preparation of this number of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, we are again indebted to the Michigan Heart Association and its Secretary, J. G. Bielawski, M.D., for the cover and the papers bearing on Heart Disease. Other material is to be considered as general supply and of independent origin. We again thank our assistants in accumulating special articles, many of which are Heart Association-sponsored or accepted research.

WINDSOR MEDICAL SERVICE

On November 8, 1957 at Ann Arbor, the University of Michigan issued a long report on the Windsor Medical Service which had just been completed. The Michigan State Medical Society had known that such a survey was being conducted by S. J. Axelrod, M.D., and Nathan Sinai, D.P.H., from the Department of Public Health Education at the University. The Governor's Commission studying Blue Cross-Blue Shield had ordered a study and suggested Dr. Axelrod to conduct it. The Michigan State Medical Society warned that any study, to be of value, had to be unbiased and recommended that a different survey method be employed.

Newspaper clippings and this report from Ann Arbor are all in glowing terms of the success of the Windsor Medical Service program which it says has been in operation for twenty years—a slight misstatement. (The first policies were sold in July, 1939, but in 1945 there were only 7,656 subscribers). The numbers have increased until in December 1955, there were 171,000.

The report quotes the subscribers as being very satisfied and the doctors as being "satisfied." It claims that a very small per cent of the doctors of the Windsor area have some criticism.

Press reports are that the Windsor physicians are very favorable—92 per cent of them—and that is about the number who are participating. We also received from the Health Information Foundation of New York a six-page, fairly detailed report of this survey. They sponsored it and financed it. The report was made by Benjamin Darsky, M.A., Nathan Sinai, D.P.H., and Solomon J. Axelrod, M.D., M.P.H., and will be published by the Harvard Press in 1958. This report says 63 per cent of the Windsor physicians reported an increase in the proportion of their income derived from Windsor Medical Service over the few years prior to the survey year, 1954. (Naturally, because the subscribers grew from 7,657 to 171,000). Of these doctors, 40 per cent were very satisfied with this increased dependence on the plan, 42 per cent were fairly satisfied, 15

(Turn to Page 79)

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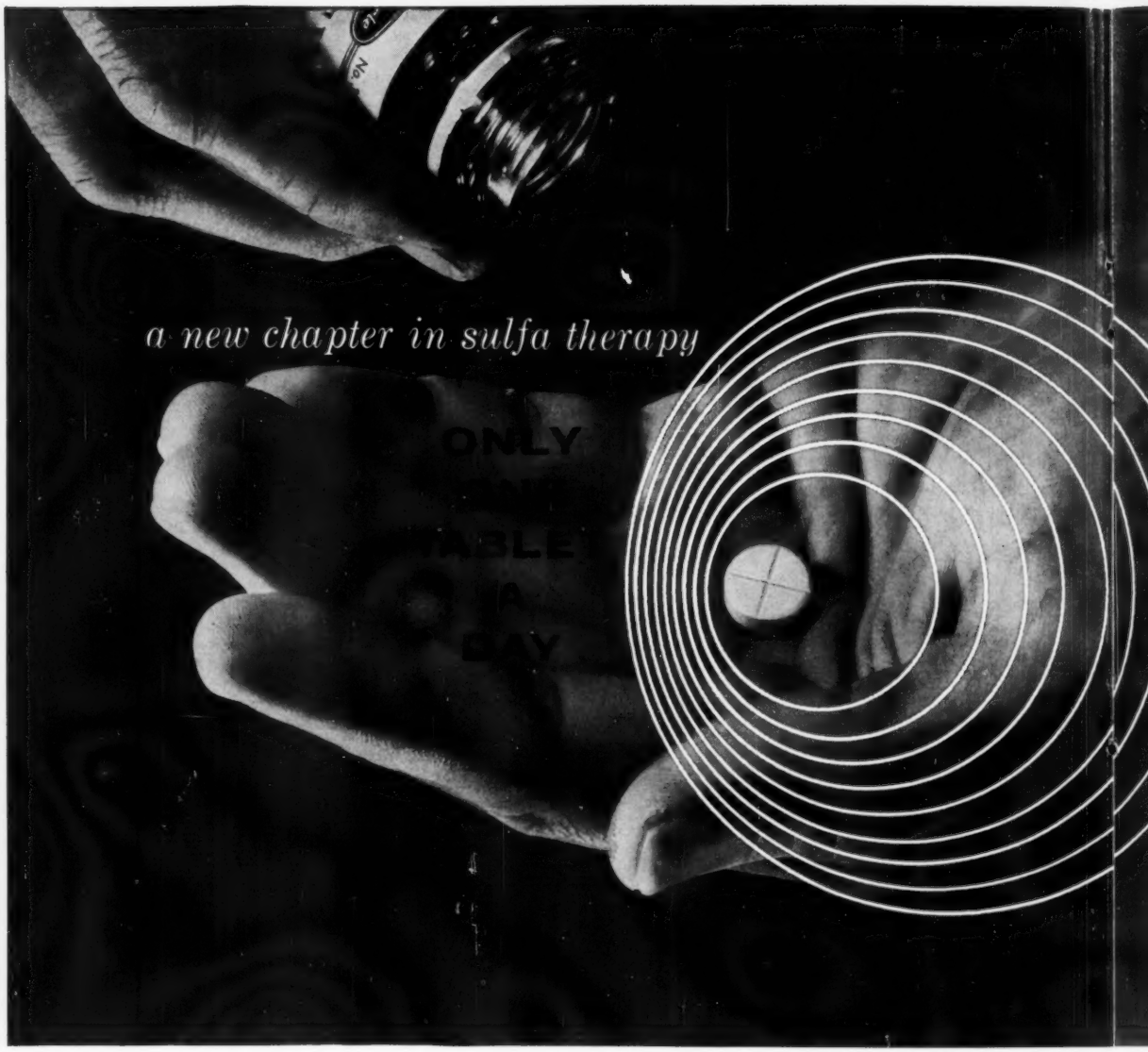

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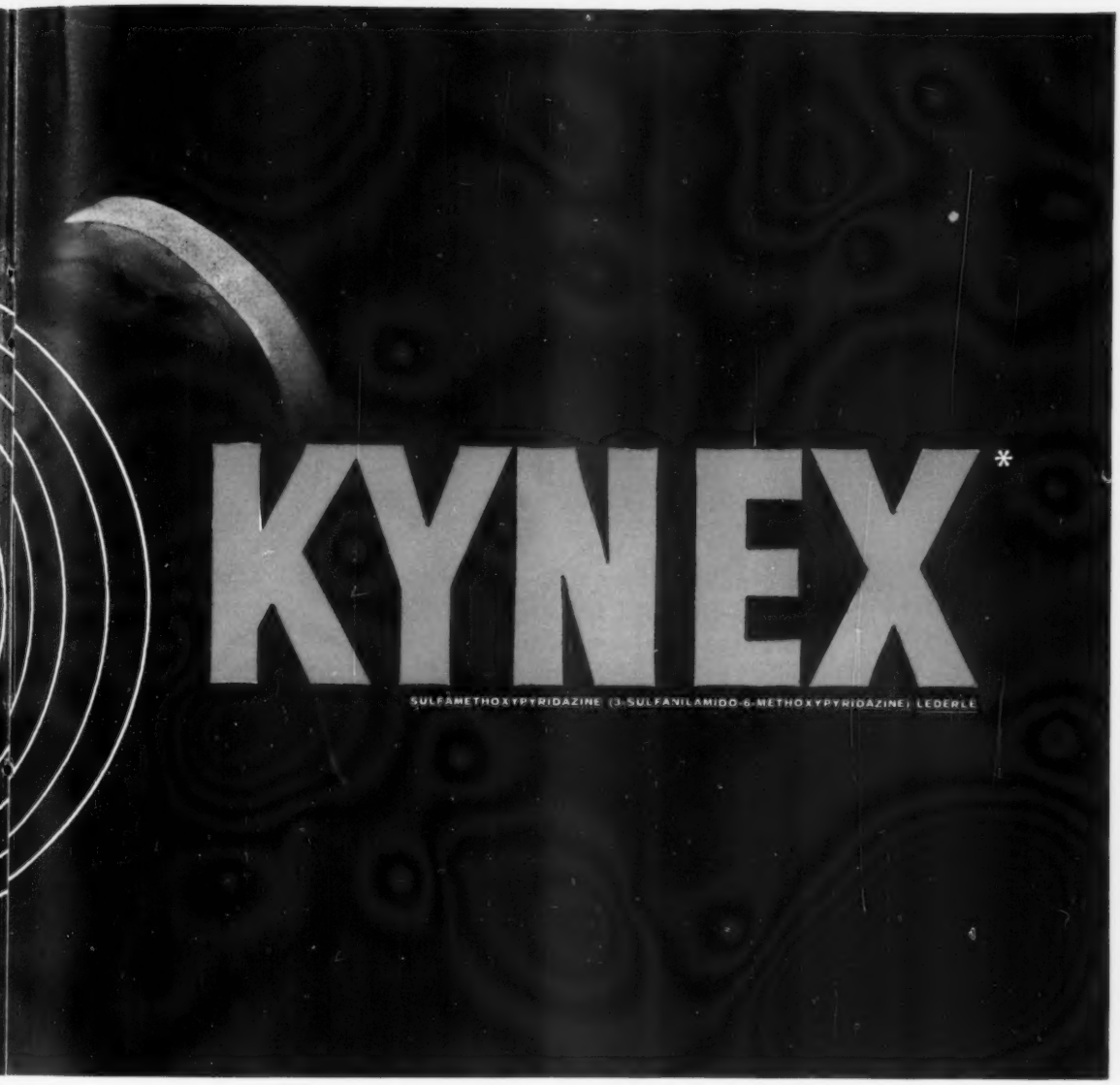
1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.



NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

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Prevailing opinion holds that during the nephrotic state—provided the kidneys are capable of excreting nitrogen in a normal manner—the patient should be given a diet high in protein (1.5 to 2 grams per kilogram of body weight daily). The purpose of such a diet is to replace depleted plasma protein and to increase the colloidal osmotic pressure of the blood.

Sharp restriction of dietary salt appears indicated only in the presence of edema, but moderate restriction is usually recommended.

Lean meat is admirably suited for the diets prescribed in most forms of renal disease. It supplies relatively large amounts of high quality protein and only small amounts of sodium and chloride. Each 100 Gm. of unsalted cooked lean meat (except brined or smoked types) provides approximately 30 Gm. of protein, and only about 100 mg. of sodium and 75 mg. of chloride.

In addition to its nutritional contributions meat fulfills another advantageous purpose: It helps make meals attractive and tasty for the patient who must rigidly adhere to a restricted dietary regimen.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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per cent were somewhat satisfied and 2 per cent were very dissatisfied. About two-thirds agreed that Windsor Medical Service had been generally in the best interests of physicians. Another 29 per cent believed that in some ways it had, but in other ways it had not.

Relative to the fee schedule itself—27 per cent were satisfied, 55 per cent believed it required some change, another 16 per cent believed that "major revision is needed." Most physicians are satisfied with the so-called "taxing" procedures by which a physician's claims are reviewed and adjusted if deemed excessive. About 95 per cent of the claims received by the plan are processed routinely; the remaining 5 per cent require some consideration by the medical director, or by the "medical control committee." As a result of this, an average reduction is made of about 3 per cent of the total claims submitted by participating physicians. None of these facts was in the newspaper releases.

On April 27, 1957, at the extraordinary session of the MSMS House of Delegates, Max L. Lichter, M.D., Detroit, made a report on the Windsor Plan, after a very thorough study. Here are some quoted items:

"The Plan pays about 90 per cent of schedule when proration of income is adjusted to the services. The fee schedule is about 89 per cent of the Michigan Blue Shield 35,000 contract. Non-participating doctors are not paid by the Plan but payments are made to subscribers. There are various waiting periods for pre-existing conditions such as tonsils, and adenoids, hernias, gynecology and obstetrics, and for refraction—from six months to a year.

"The medical director adjudicates all disputes between the subscribers and Plan doctors and the Plan decision is usually final. One can appeal to a special committee which reports to the Board. The Medical Director reserves the right to determine adequate amount of medical care and the Plan pays accordingly. Doctors can't charge extra to patients when the Plan reduces allowances, if patient is under income. The Plan's Board and Committees police itself and are effectively reducing over-utilization. The Plan may cancel participation of an M.D. The Hospital Service is carried by the Ontario Blue Cross which had 2,158 subscribers in 1945 and only 1,062 a decade later."

PUBLIC HEALTH STUDY COMMISSION

About two years ago, a Public Health Study Commission consisting of twenty-five members was appointed, with Professor Wilbur J. Cohen of the administrative department of the School of Public Health of the University of Michigan as chairman. Dr. Cohen is professor of public welfare administration. Dr. Kenneth A. Easlick, professor of public health dentistry and Solomon J. Axelrod, M.D., professor of public health economics, are members of the commission, which delivered its report, representing fifteen months of study, to Gov. G. Mennen Williams on Thursday, November 21, 1957.

The report states that Michigan's public health problem is basically sound but lacks general vigor and active citizen interest. Four additions to the state's present health program are suggested:

1. A voluntary health insurance plan for state government employees, supported both by the employer (state) and employees;
2. State scholarships and financial assistance to qualified young women for nurses training;
3. Allocation of at least 5 per cent of all state expenditures for research in the prevention of mental illness, and
4. Establishment of seven-man local health advisory committees to encourage active citizen participation in solving local health problems.

The Commission makes twenty-three basic recommendations but stresses the following:

1. Strengthening local public health services, which are now short about $35,000,000 annually of the minimum requirements for effective local health service in all counties of the state. An immediate increase of $1,000,000 over the present state appropriation is asked, leaving the counties and cities to raise about $4,000,000 annually.
2. Strengthening services for persons chronically ill with cancer and heart disease, frequent causes of death in Michigan. Preventative studies will become increasingly vital as our population grows and ages.
3. Expansion of home care visiting nurse associations in counties which do not now have them. Funds should be provided by the state for an adequate staff to carry out inspections and licensing as defined by law for nursing homes and homes for the aged.
4. Establishing chronic disease units as integral parts of the teaching hospitals at the University of Michigan and Wayne State University plus construction of chronic disease wings in the larger general hospitals throughout the state.

Mental Health.—The state's mental health program has been improving recently in all phases but needs expansion of training program for clinical psychologists, psychiatrists and psychiatric social workers. "We need at least three new child guidance clinics and one addition of psychiatric clinic for adults." For the prevention of mental illness, the Commission advises a joint program

by the State Department of Health and State Department of Mental Health to aid prevention and relapse in mental illness.

Human Resources.—The Commission recommends the state government support research and service in the utilization of human resources; continued polio immunization; investigation of effects of radiation and air pollution; enactment of a pure food, drug and cosmetic law; and development of a home and traffic accident prevention.

To meet these recommendations, the commission urges recruiting additional manpower in the fields of health and mental health. It advises expanding Wayne State University's medical college by fifty graduates a year and immediately establishing a third medical school in Michigan.

Dentists, although fairly plentiful in some counties, constitute a critical shortage in others. It is recommended that the legislature expand the University of Michigan School of Dentistry from ninety-seven to one hundred and fifty graduates per year and establish a more vigorous campaign for fluoridation by the State Department of Health.

Vocational Rehabilitation.—The Commission charges that Michigan currently is doing only one-seventh of the job that needs to be done in vocational rehabilitation. The program neglects virtually the entire mentally handicapped population, large areas of the chronically ill, the aged-handicapped, the homebound, and youth of school age. It recommends an appropriation of $1,127,000 for rehabilitation and a proposed 32-bed multiple disability facility at the University of Michigan Medical Center and strengthen the State Workmen's Compensation Law for rehabilitation of injured workers.

Migrant Workers.—Michigan's migrant working families are increasing in numbers and the health conditions should be looked into, involving necessary plans for a practical and effective way of determining the kinds of health problems these families have, and developing basic health services for them including financing these projects through the State Health Department and legislative appropriations.

Home Tuberculosis Patient Care.—Post-sanatorium care for tuberculosis patients is needed to prevent relapse and to protect the state's investment of many thousands of tax dollars in their initial treatment. Three out of ten are reported to relapse.

AGAIN "AGIN"

After reading the AMA Secretary's Letter of November 15, we are unable to escape the feeling that the medical profession has again been maneuvered into a position of fixed opposition. Other newsletters, the AMA Washington Letter, and the Washington Report on the Medical Sciences, help to confirm that opinion. This AMA Secretary's Letter called attention to the Forand Bill HR 9467, 85th Congress, which proposes that the government, through the Social Security System, pay the cost of hospital, nursing home and surgical service to persons eligible for Old Age and Survivors Insurance Benefits.

"The socialized medicine proposal for a large and growing segment of the American people is essentially the same as that of 1941 to 1951 when the Wagner-Murray-Dingle bills called for National Compulsory Health Insurance, except that it applies to a smaller segment at this time"; . . . The American Medical Association has repeatedly opposed compulsory health insurance and is unequivically opposed to this new version."

The AMA Board of Trustees, at the request of the committee on legislation, has appointed a special task force composed of Drs. George M. Fister, Chairman, Frank C. Coleman, J. Duffy Hancock, George Gsell and Robert L. Novy (the last from Detroit).

Walter Polner, Ph.D., of the staff of the Bureau of Medical Economics Research, has been assigned full time to the task force and is conducting an intensive research study of the health status of the population over the age of sixty-five. We are reminded of the establishment of the National Physician's Committee, whose activities were approved by the House of Delegates at the AMA, June, 1942, meeting, asking physicians to interview congressmen and oppose the national compulsory health and sickness insurance (Wagner-Murray-Dingle) bills.

We Opposed

Wagner-Murray-Dingle editorials and items were published frequently. We are also reminded that the AMA issued a special assessment of $25 on each member and hired the Public Relations

firm of Whitaker and Baxter to conduct a National Education Campaign, January, 1949, to 1952. In October, 1943, THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY had an editorial, "They Never Sleep," calling attention to the concerted and directed effort to extend the socialization of medicine. In November, 1943, it had a five-page spread, entitled "S 1161—The Sign at the Crossroads," *abolishing* private medical practice.

We realized gradually that we were constantly opposing some legislation instead of offering a solution, so in January, 1944, THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY published an editorial, "Have We a Program?," followed the next month by two others: "Evolution and Democracy" and "Developing a Program." Michigan's program at that time was primarily the work of Michigan Medical Service demonstrating that the private practice of medicine was able to render to the people the essential and necessary services which they needed at a price they could pay and *without* the domination of a compulsory program.

The profession fought "political medicine" and enlisted the aid of many other organizations. The Michigan State Medical Society took a "political opinion survey" in 1944 in an effort to eliminate threatening government medicine. We suggested that medical treatment for veterans through the home-town programs be established. In March, 1945, we had three editorials "Wagner-Murray-Dingle Again," "We Have the Answer" and "Our Proposal," ending with this statement: "Expansion of the Michigan Medical Plans can now be rapid, and must be, to meet the proposals of the apostles of 'Complete security for all.' "

Through the years, the Michigan State Medical Society has been proposing that we do something positive in opposition to the compulsory health insurance program of Wagner-Murray-Dingle and others. We were in conference with the late Senator Vandenberg on various items and he told us the best way to oppose some legislation we do not like is to offer something better. This has been done through our prepayment program. Senator Vandenberg soon had his attention directed mostly to international affairs, so turned over to Senator Robert Taft the fight which the profession was making against socialized medicine.

More conferences, newspaper comment, newsletters after which Senator Taft proposed a more direct action—that a bill be introduced into the Congress which had the complete sponsorship of the medical profession. Committees, including one from the Conference of Presidents and Other Officers of State Medical Societies, conferred upon the principles which should be included, and on March 3, 1946, Senator Taft introduced his bill—the Taft Bill S2143. The medical profession was now fighting for something. *We had a program.* (The Taft Bill divided attention, gave us something to actively support and was abandoned when it had served its purpose to kill the Wagner-Murray-Dingle effort.)

The prepayment medical care programs throughout the nation, with their unprecedented success and the addition of a more favorable political attitude in Washington, has suppressed the compulsory health insurance program to the point where many of our doctors actually believe the threat has disappeared.

THE FIGHT CONTINUES

For the past couple of years, there has been extreme pressure upon the prepayment programs by certain groups who have not forgotten the power and prestige which might have been theirs. Some members of these groups are still in the government bureaus. Others are in our various institutions, teaching, making surveys and studies, and others are dismayed by the increasing costs of medical and health care due to most modern and very specialized services and values and are demanding complete or almost complete health care supplied by government. These pressures are reviving some or all parts of the old socialized medical compulsory health insurance program. Again the AMA has set up a task force, outlined a course of action, and has placed itself unalterably opposed to certain of the bills now in Congress, especially the Forand Bill HR 9467, placing on social security the costs of medical care for every beneficiary of the social security program; and the Dingle bill which includes all of the old Wagner-Murray-Dingle provisions which have not already been enacted.

The profession, in general, is once more placed upon the defensive, put in the unenviable position of always opposing some proposed legislative action.

Again Michigan steps forward to lead the way. Our State Medical Society has conducted an extensive survey to determine the wishes of the people and the doctors and has adopted unanimously, through its House of Delegates, a set of principles

to govern the distribution of prepaid medical service. A complete rejuvenation of the program has been ordered, new and revolutionary contracts are being devised, our fee and rate schedule is being completely revised, and we have proposed to guarantee this service to our under-income-limit subscribers.

Keen observers of the whole medical service philosophy believe the private practice of medicine may still be saved by private enterprise, justly, freely and adequately supplied, to the satisfaction of our patients and to our own advantage. The medical profession, by its very nature, is composed of rugged individualists; a great proportion of our keen diagnoses and expert service is made by the individual or small groups working together. The profession has always resented dictation by government or by organizers and pressure groups. Many have complained "no insurance company or other group is going to dictate to me what I may charge my patients."

Michigan Medical Service is not an insurance company or a pressure group. It is actually an integral part of the Michigan State Medical Society. It is incorporated and operated as a financial structure on business methods, but its control is through a Board of Directors elected by the membership, which is the House of Delegates.

Michigan believes it has an active and aggressive answer to the present threat to socialize medicine.

GREETING THE NEW YEAR

We approach the New Year with the confident expectations that it will have new questions, new problems, new tasks to perform and new experiences. The year just past gave us several problems in the field of socio-economic medicine. We believe the medical profession of Michigan is working out the answer to most of these problems. A year ago, we were not concerned with particularly extraordinary questions. We were concerned with Blue Shield finances, the necessity of increased rates and the thought in the minds of many of us that the coverage offered by our Michigan Medical Service must be expanded and made more adequate. That is now in the process of fruition.

At this time last year, the Medicare program had been established and was just beginning to function. Blue Shield Commission was negotiating with the federal government on a proposition to establish medical and health insurance for the federal employes and their dependents. How to give services to the over 2 million civilian employes and their dependents was being considered and negotiated. It is still in abeyance but is very much in the public eye, and this year will probably see some action to take care of these several million people.

We could very readily have this same question in Michigan apply to the state employes. That suggestion was made in the Public Health Study Commission report submitted recently to the Governor. The authors of that report were the sponsors and architects of the Windsor Medical Service, who usually have socializing ideas. Our Michigan Blue Cross and Blue Shield stand ready and willing to give complete services to the State of Michigan for the care of employes and their dependents if they desire. It is not necessary to create a new plan on a socialistic basis.

For several years, the present federal administration has been suggesting that some way be found to furnish health insurance to the indigent, medically indigent, the low income groups, and those on public assistance—a so-called reinsurance program was suggested. That, however, was so complicated that no one was interested. This is another area where health insurance is needed and, we believe, can be obtained. Suggestions and programs can and will be worked out to cover this particular area of medical care. We, in Michigan, toyed with this problem a few years ago. Our proposed solution failed because of rejection from Washington. We are confident of the future. We have the plan.

"MARCH OF MEDICINE" TV PROGRAM

The work of American physicians in remote regions of the world where native populations are largely dependent upon our doctors and medicine for their health and well-being is the television story to be aired coast-to-coast on January 23. Entitled "MD International," the hour-long show will be presented at 10 p.m. EST over the full NBC-TV network both in color and black and white. This is part of a joint American Medical Association and Smith, Kline & French Laboratories project to inform the American public of people-to-people activities in the health profession for the promotion of better international understanding.

The telecast reports on doctors' activities in thoracic and general surgery, orthopedics, ophthalmology and general medicine in such far-flung areas as Korea, Hong Kong, Burma, Sarawak, Nepal, India, Lebanon and Ethiopia. A special March of Medicine team traveled more than 34,000 miles to film these doctors in their unofficial roles as America's medical diplomats.

Actions of the AMA House of Delegates

December 3-6, 1957

Most of the work at the December meeting of the AMA House of Delegates was routine. More than thirty resolutions were prepared for presentation, a few were not presented because they were duplicated and some were withdrawn. Most controversial problems were decided by discussion at the reference committee conferences as has been the case for so many years, but three items came up for general discussion when the reference committee reports were presented to the House at the last session Thursday morning, December 5.

Fluoridation of public water supplies, free choice of physician, the Heller Report on organization of the American Medical Association, the Forand Bill providing hospital and surgical benefits for Social Security beneficiaries, guides for occupational health programs covering hospital employes, distribution of Asian Influenza vaccine and guides for the medical rating of physical impairment were among the variety of subjects acted upon by the House of Delegates at the American Medical Association's Eleventh Clinical Meeting held December 3-6, in Philadelphia.

Dr. Cecil W. Clark of Cameron, Louisiana, was named 1957 General Practitioner of the Year after his selection by a special committee of the Board of Trustees for outstanding community service. Dr. Clark, thirty-three-year-old country doctor who was a medical hero during Hurricane Audrey last June, was present at the meeting to receive the gold medal which goes with the annual award.

Speaking at the opening session on Tuesday, Dr. David B. Allman of Atlantic City, AMA President, called for "more freedom, not less, in America and in the medical profession." Dr. Allman urged the delegates to embark on local action campaigns to enlist full community support in opposition to the Forand Bill, a pending Congressional proposal which would provide hospital and surgical benefits for persons who are receiving or are eligible for Social Security retirement and survivorship payments. The Forand Bill, he said, is "cut from the same cloth" as national compulsory health insurance and "emanates from the same minds."

Total registration at the end of the third day of the meeting, with half a day still to go, had reached 5,375, including 2,562 physician members.

Fluoridation of Water

In settling the most controversial issue at the Philadelphia meeting, the House of Delegates approved a joint report of the Council on Drugs and the Council on Foods and Nutrition which endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood. The twenty-seven-page report on the study which was directed by the House at the Seattle Clinical Meeting one year ago contained these conclusions:

"1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to ten years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluorine content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least forty-four years of age.

"2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

"3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine."

This item, when it came to the floor of the House on Thursday morning, December 5, met open discussion and attempted amendment in spite of the full discussion offered in the reference committee.

An amendment was proposed to the effect that while fluoridation might be of benefit, the AMA restated its opposition to compulsory treatment for the prevention of non-contagious disease. This amendment was rejected by divided vote when it was realized that the reference committee statement is simply one of endorsement of treatment plan and says nothing whatever about compulsion.

Free Choice of Physician

Acting on the issue of free choice in relation to contract practice, the House passed a resolution which reaffirmed approval of previous interpretations of the Principles of Medical Ethics by the Association's Judical Council and directed that they be called to the attention of all constituent associations and component societies. One Council

opinion, issued in 1927 and reaffirmed in Philadelphia, stated that the contract practice of medicine would be determined to be unethical if "a reasonable degree of free choice of physician is denied those cared for in a community where other competent physicians are readily available." The resolution also cited a Council opinion, published in the October 19, 1957, issue of *The Journal of the American Medical Association,* which stated that the basic ethical concepts in both the 1955 and 1957 editions of the Principles of Medical Ethics are identical in spite of changes in format and wording. This opinion added that "no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 principles."

The 1927 Council report also pointed out that "there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided." Judgment of whether or not a contract is ethical, the report said, must be based on the form and terms of the contract as well as the circumstances under which it is made.

In another action related to the issue of free choice, the House adopted a resolution condemning the current attitude and method of operation of the United Mine Workers of America Welfare and Retirement Fund "as tending to lower the quality and availability of medical and hospital care to its beneficiaries." The resolution also called for a broad educational program to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the "Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund" which were adopted by the House last June.

The Heller Report

The Heller report, probably the most important item considered by the House of Delegates at this meeting, was reported by the Board of Trustees at the close of the meeting in June at New York as having been received and studied by the Board and was being referred to a special committee of the House for a thorough study and report at the December meeting in Philadelphia. William A. Hyland, M.D., of Michigan, was the chairman of this study committee. The Heller report was voluminous, containing nearly 100 pages. In some ways, it was quite critical and, in some ways, it had some very good suggestions. In some ways, it gave evidence of not sufficient study of certain activities before making the report. The Heller survey had been made and the Hyland committee study "to promote efficiency of management of the Association's policy and activities." The Heller report had evidently been made with the idea that the Board of Trustees corresponded to a Board of Directors of a corporation and should act accordingly. The reference committee, in its report which was adopted, had carefully studied the Heller report and the Hyland committee report in detail and gave due consideration to the opinions expressed by a large number of delegates, officers, members of the Board of Trustees and members of the Association who appeared before the committee. The Hyland committee had made comments on certain major administrative items which are of general interest. The reference committee concurred with the Hyland committee that these comments do not require House of Delegates action but can be handled administratively and are so being handled at the present time. The Hyland committee made ten recommendations on matters of policy which, in its opinion, do require action by the House of Delegates, especially Number 7 which proposed electing the members of the Board of Trustees, one each from designated physician-population areas.

Acting on the Report of the Committee to Study the Heller Report on Organization of the American Medical Association, the House reached the following decisions on ten specific recommendations:

1. The office of Vice President will be continued as an elective office.
2. The offices of Secretary and Treasurer will be combined into one office to be known as Secretary-Treasurer, and that officer will be selected by the Board of Trustees from one of its number.
3. The duties of the Secretary-Treasurer will be separated from those of the Executive Vice President.
4. The office of General Manager will be discontinued, and the new office of Executive Vice President will be established. The latter, appointed by the Board of Trustees, will be the chief staff executive of the Association.
5. The Council on Medical Education and Hospitals and the Council on Medical Service will continue as standing committees of the House of Delegates, but their administrative direction will be vested in the Executive Vice President.
6. The voting members of the Board of Trustees will be limited to eleven—the nine elected Trustees, the President and the President-Elect. The Vice President and the Speaker and Vice Speaker of the House of Delegates will attend all Board meetings, including executive sessions, with the right of discussion but without the right to vote.
7. The House disapproved of the proposal to elect the Trustees from each of nine physician-population regions.
8. The office of Assistant Secretary will be discontinued, and a new office of Assistant Executive Vice President will be established.
9. The Committee on Federal Medical Services will be retained as a committee of the Council on Medical Service and will not become a part of the Council on National Defense.
10. The Speaker of the House will appoint a joint and continuing committee of six members, three from the Board of Trustees and three from the House, to redefine the central concept of AMA objectives and basic programs, consider the placing of greater emphasis on scientific activities, take the lead in creating more

cohesion among national medical societies and study socio-economic problems.

The accepted recommendations were referred to the Council on Constitution and By-laws with a request to draft appropriate amendments for consideration by the House at the 1958 annual meeting in San Francisco.

The Forand Bill

The House condemned the Forand Bill as undesirable legislation, approved the firm position taken in opposition to it and expressed satisfaction that the Board of Trustees has appointed a special task force which is taking action to defeat the bill. In a related action, giving strong approval to Dr. Allman's address at the opening session, the House adopted a statement which said:

"It is particularly timely that our President has so forcefully sounded the clarion call to the entire profession for emergency action. With complete unity, definition and singleness of purpose, closing of ranks with all age groups and elements of our organization we must at this time stand and be counted. Thus we can exert the physician's influence in every possible direction against invasion of our basic American liberties in the form of proposed legislation alleged to compulsorily insure one segment of the population against health hazards at the expense of all."

Health Programs for Hospital Employees

A set of "Guiding Principles for an Occupational Health Program in a Hospital Employe Group" was approved by the House. The guides were developed by a joint committee of the American Medical Association and the American Hospital Association and already had been formally approved by the AHA. They include these statements:

"Employees in hospitals are entitled to the same benefits in health maintenance and protection as are industrial employees. Therefore, programs of health services in hospitals should use the techniques of preventive medicine which have been found by experience in industry to approach constructively the health requirements of employees.

"It is essential that employee health programs in hospitals, as in industry, be established as separate functions with independent facilities and personnel. The fact that hospitals are engaged in the care of the sick as their primary function does not alter the necessary organizational plan for an effective occupational health program."

Asian Influenza Vaccine

The House considered three resolutions dealing with the Asian influenza immunization program and then adopted a substitute resolution calling attention to "certain inadequacies and confusions in the distribution of vaccines" and directing the Board of Trustees to seek conferences through existing committees "with a view to establishing a code of practices regulating the future distribution of important therapeutic products, so that the best interest of all the people may be served." The resolution pointed out that the American Medical Association already has a joint committee with the American Pharmaceutical Association and the National Association of Retail Druggists, in addition to a liaison committee with the Drug Manufacturers Association.

Medical Rating of Physical Impairment

The House accepted a 115-page "Guide to the Evaluation of Permanent Impairment of the Extremities and Back" which was developed by the Committee on Medical Rating of Physical Impairment as the first in a projected series of guides. The delegates commended the committee for doing a "superb job on this difficult subject" and expressed pleasure that the guides will be published in *The Journal of the American Medical Association*. The guides are expected to be of particular help to physicians in determining impairment under the new disability benefits program of the Social Security Act.

Miscellaneous Actions

Among a wide variety of other actions, the House also:

Directed that a new committee be established in the Council on Industrial Health to study *neurological disorders in industry;*

Noted with approval the establishment of the American Medical Research Foundation, which will initiate and encourage necessary *medical research* and correlate and disseminate the results of studies already under way;

Decided that informational materials which are sent to A.M.A. delegates should also be sent to all *alternate delegates;*

Affirmed that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other *lawful groups* provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians;

Instructed that the appropiate committee or council should engage in conferences with *third parties* to develop general principles and policies which may be applied to the relationship between third parties and members of the medical profession;

Urged state medical society committees on aging and insurance to make continuing studies of *preretirement financing of health insurance* for retired persons;

Endorsed a suggestion that the Committee on Federal Medical Services sponsor a national conference on *veterans' medical care* during 1958;

Asked the Board of Trustees to study the feasibility of having the Association finance a thorough investigation of the *Social Security* system by a qualified private agency;

Suggested that physicians and their friends make

a vigorous effort to obtain Congressional enactment of the *Jenkins-Keogh Bills;*

Approved the "Suggested Guides to Relationships Between Medical Societies and *Voluntary Health Agencies*";

Strongly recommended that a completely adequate and competent medical department be established in the *Civil Aeronautics Administration* directly responsible to the CAA Administrator, and

Congratulated the General Electric Company for its medical television presentations on the subject of *quackery.*

Opening Sessions

At the Tuesday opening session, Rear Admiral B. W. Hogan, Surgeon General of the U. S. Navy, presented the Navy Meritorious Public Service Citation to Dr. Dwight H. Murray of Napa, California, immediate past president of the Association. Contributions to the American Medical Education Foundation, for financial aid to the nation's medical schools, were presented by four state medical societies: California, $143,043.25; Utah, $10,390; New Jersey, $10,000, and Arizona, $8,040. The Interstate Post Graduate Medical Association of North America gave $1,000, and the Illinois State Medical Society announced that it was adding $10,000 to the $170,450 presented at the New York meeting last June.

Registration

The total registration for the four-day meeting was 6,900, including 2,637 physicians. At the Seattle meeting last year, the total was 6,282 including 2,813 physicians. The two-day snowstorm, with streets and highways blocked off and taxis not even running, accounted for the poor attendance in Philadelphia. On account of the large doctor population around Philadelphia, it was expected that many more would be present.

* * *

We are indebted to Geo. F. Lull, M.D., Secretary of the A.M.A., for portions of this report.

PSYCHIATRIC SYMPTOM FORMATION

(Continued from Page 76)

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MSMS Ninety-Second Annual Session—1957
House of Delegates Proceedings

TABLE OF CONTENTS

		Introduction of Business	Reference Committee Report	
27.	Woman's Auxiliary Sponsorship of Freedom Essay Contest	123	130	approved
28.	Commendation to L. R. Leader, M.D., Detroit	123	125	approved
29.	Recommendation to Joint Accreditation Commission to Establish a New Section on Special Services	123	125	disapproved
30.	Adding Physiatrists in present MSMS Radiology-Anesthesiology-Pathology Section	123	125	disapproved
31.	Creation of MSMS Advisory Committee to Michigan Medical Service	123	138	no action
32.	Comprehensive Medical Service Plan	117	134	no action
33.	Recognition of Pathology under Medicare	From April 1957 House of Delegates	130	amended and approved
34.	Recognition of Pathology in Blue Cross-Blue Shield	From April 1957 House of Delegates	130	amended and approved
35.	Recognition of Internists	From April 1957 House of Delegates	134	disapproved
36.	To change Michigan Hospital Service-Michigan Medical Service into Indemnity Plans	From April 1957 House of Delegates	134	disapproved
37.	Limit Blue Shield Contracts to Those in Specified Income Limits	From April 1957 House of Delegates	135	disapproved
38.	Increased Benefits in Michigan Medical Service Contracts	From April 1957 House of Delegates	135	referred to Michigan Medical Serv.
XIII.	Report of Permanent Advisory Committee on Fees	117	124	approved
XIV.	Reports of Standing Committees			
1.	Committee on Postgraduate Medical Education	118	119	approved
2.	Preventive Medicine Committee and Sub-Committees	118	119	approved
3.	Public Relations Committee and Sub-Committees	118	119	approved
4.	Ethics Committee	118	119	approved
5.	Legislative Committee and Sub-Committees	118	119	approved
XV.	Reports of Special Committees			
1.	Beaumont Memorial Committee	118	119	approved
2.	Scientific Radio Committee	118	119	approved
3.	Advisory Committee to Woman's Auxiliary	118	119	approved
4.	Advisory Committee to Michigan State Medical Assistants Society	118	119	approved
XVI.	Reports of Reference Committees			
1.	On Officers' Reports		119	
	(a) President's Address (119); (b) President-Elect's Address (119); (c) AMA Delegates (119); (d) Woman's Auxiliary (119); (e) Michigan State Medical Assistants Society (119); (f) Resolution re Woman's Auxiliary Sponsorship of Freedom Essay Contest (130)			
2.	On Reports of Standing Committees		119	
3.	On Reports of Special Committees		119 & 124	
	(a) Beaumont Memorial; Scientific Radio; Advisory to Woman's Auxiliary; Advisory to Michigan State Medical Assistants Society (119); (b) Permanent Advisory Committee on Fees (124)			
4.	On Constitution and By-Laws		119	
	(a) Resolution re Section Representation in MSMS House of Delegates—Constitution, Article VII, By-Laws, Chapter 8, Section 1 (117 & 119); (b) Resolution re Regulation of Membership—E. H. Fenton—By-Laws, Chapter 2, Section 1 (114 & 119); (c) Discipline of Members—Adler—By-Laws, Chapter 6 (119); (d) Mediation-Ethics-Grievance—By-Laws, Chapter 6, new Chapter 7 (119 & 122).			
5.	On Resolutions		120	
	(a) Annual Report of Healing Arts Study Committee (120); (b) Resolution re Referral to AMA of Healing Arts Problem (120); (c) Collection of Dues (125); (d) Insurance Reporting Forms (125); (e) Recommendation to Joint Accreditation Commission to Establish New Section on Special Services (125); (f) Adding Physiatrists in Present MSMS Radiology-Anesthesiology-Pathology Section (125).			

MSMS House of Delegates—1957

Summary of Proceedings

The Ninety-second Annual Session of the Michigan State Medical Society's House of Delegates was held in Grand Rapids, September 23-24-25, 1957.

The House of Delegates:

1. Adopted with thanks the President's Address, the President-Elect's Address, the report of Delegates to the American Medical Association, the Annual Report of the President of Woman's Auxiliary to Michigan State Medical Society, and the Annual Report of the President of Michigan State Medical Assistants Society.

2. The Annual Reports of The Council (including the Annual Reports of Committees of The Council) were adopted as amended. This included approval of bylaws amendments—to Chapter 6 and new Chapter 7—concerning mediation-ethics-grievance, as amended, with deletion of "representation by counsel." Action on The Council Reports also included approval of two of the four recommendations of the Committee on Study of Healing Arts, as follows: (a) That the Michigan State Medical Society Delegates to the AMA House of Delegates be instructed to submit a resolution to the AMA House of Delegates at that body's next session, requesting the referral of the problem of M.D.'s and D.O.'s relationship to the individual constituent state medical societies for action by their individual houses of delegates, and that actions, subsequently taken on this question by these houses, be considered ethical in relation to the AMA Principles of Ethics; (b) That the Michigan State Medical Society agree to having its Legislative Committee meet (annually) when necessary with the like committee of the Michigan Association of Osteopathic Physicians to attempt to iron out any mutual legislative problems.

Action on The Council Reports also included approval of Report of Committee on Michigan Medical Service, as amended; also approval of the following plan for the financing of the new MSMS headquarters building:

That to the present $5.00 per member dues allocated for the building fund, an additional $5.00 be levied upon each member for 1958; an additional $5.00 be levied upon each member for 1959; an additional $10.00 be levied upon each member for 1960, and an additional $10.00 be levied upon each member for 1961, the total for four years being $50.00 per member.

Thus the dues in 1958 and 1959 will be $60.00 per member, and in 1960 and 1961, $65.00 per member.

3. Adopted Annual Reports of all Standing Committees and of all Special Committees of the Society; also the report of the Permanent Advisory Committee on Fees which was directed to continue its studies.

4. Elected Paul Van Riper, M.D., Champion, as Michigan's Foremost Family Physician for 1957.

5. Approved the MSMS-sponsored Opinion Study of Pre-paid Medical Care Coverage, including the Report of the Committee on Michigan Medical Service, G. W. Slagle, M.D., Chairman (see November JOURNAL for detailed report).

6. Approved the amended Report of the Committee to Study Comprehensive Pre-paid Insurance Plans, C. I. Owen, M.D., Chairman.

7. *Took action on proposed amendments to the Constitution and By-Laws, as follows:* (a) By-Laws, Chapter 6 and new Chapter 7 re mediation-ethics-grievance—approved as amended (supra, Item 2); (b) Constitution, Article X, Sections 1-2-3, and By-Laws, Chapter 9, Section 1, making Vice Speaker a voting member of The Council and its Executive Committee—approved; (c) Constitution, Article VII and By-Laws, Chapter 8, Section 1, giving representation in MSMS House of Delegates to Sections—referred to 1958 House of Delegates; (d) By-Laws, Chapter 2, Section 1 re regulation of membership—disapproved; (e) By-Laws, Chapter 6, re discipline of members—disapproved.

8. *Adopted resolutions concerning:* (a) Federated fund raising—approved in principle; (b) Honorary Membership to Wm. J. Burns, LL.B.; (c) Referral of healing arts problem to A.M.A.; (d) Expansion of medical school facilities; (e) Training of ambulance drivers; (f) Collection of MSMS dues; (g) Pilot Study of Insurance Reporting; (h) Woman's Auxiliary's sponsorship of Freedom Essay Contest; (i) Commendation to Luther R. Leader, M.D., Detroit; (j) Annual registration of M.D.'s (as amended); (k) Recognition of Pathology under Medicare; (l) Recognition of Pathology in Blue Cross-Blue Shield.

9. Referred to The Council a resoultion re distribution of influenza vaccine.

10. Referred to Michigan Medical Service resolution re Increased Benefits in Michigan Medical Service contracts.

11. *Adopted substitute resolutions concerning:* (a) Establishment of full-time chairs of preventive medicine and public health in Michigan's Medical schools; (b) Creation of Study Committee re Practice Privileges in Public Hospitals.

12. *Took no action on resolutions concerning:* (a) Free choice of physician in all medical service plans. (b) Creation of MSMS Advisory Committee to Michigan Medical Service; (c) Comprehensive medical service plan.

13. Tabled resolution concerning study of relative value schedule of services.

14. *Disapproved resolutions concerning:* (a) Proposed increase in dues for building fund (Thorup); (b) Proposed increase in dues for building fund (Babcock); (c) Merger of Blue Shield-Blue Cross; (d) Separation of Blue Cross-Blue Shield; (e) Creation of national or state clearing committee to investigate new drug claims; (f) Representation on Michigan Medical Service Board; (g) Inclusion of M.D.'s under Social Security; (h) Study of need for third medical school in Michigan; (i) Recommendation to Joint Accreditation Committee to establish new section on special services; (j) Adding physiatrists in present MSMS Radiology-Anesthesiology-Pathology Section; (k) Recognition of Internists; (l) To change MHS-MMS into Indemnity Plans; (m) Limit Blue Shield Contracts to those in Specified Income Limits.

15. *Elected the following officers:*

(a) J. F. Beer, M.D., St. Clair, as Councilor of the 7th District (1962)
(b) E. S. Oldham, M.D., Breckenridge, as Councilor of the 8th District (1962)
(c) D. G. Pike, M.D., Traverse City, as Councilor of the 9th District (1962)
(d) O. J. Johnson, M.D., Bay City, as Councilor of the 10th District (1962)
(e) W. A. Hyland, M.D., Grand Rapids (1959); J. S. DeTar, M.D., Milan (1959); and C. I. Owen, M.D., Detroit (1959), as Delegates to the American Medical Association
(f) W. W. Babcock, M.D., Detroit (1959); E. F. Sladek, M.D., Traverse City (1959); and O. J. Johnson, M.D., Bay City (1959), as Alternate Delegates to the American Medical Association

(g) G. B. Saltonstall, M.D., Traverse City, as President-Elect

(h) K. H. Johnson, M.D., Lansing, as Speaker, House of Delegates

(i) J. J. Lightbody, M.D., Detroit, as Vice Speaker, House of Delegates

16. *Elected to Special Memberships:*

(a) Forty-eight members to Life Membership: (Allegan) H. H. Johnson, M.D.; (Berrien) Edward A. Miller, M.D.; (Gogebic) Charles E. Stevens, M.D.; (Ingham) J. Earl McIntyre, M.D.; (Ionia-Montcalm) Earl P. Bunce, M.D., Oscar P. Geib, M.D., Alfred E. Hollard, M.D., Perry C. Robertson, M.D; (Kent) Earle J. Byers, M.D., Ernest W. Dales, M.D., Alfred Dean, M.D., John Ver Meulen, M.D., William R. Vis, M.D.; (Lenawee) W. B. Hornsby, M.D., Philip P. Sayre, M.D., Chad A. Van Dusen, M.D.; (Saginaw) Alexander R. McKinney, M.D., John T. Sample, M.D.; (Washtenaw) Frederick A. Coller, M.D., Emory W. Sink, M.D.; (St. Clair), George Van Rhee, M.D.; (Wayne); Effie E. Arnold, M.D., T. H. Edward Best, M.D., F. W. Bramigk, M.D., Philip H. Broudo, M.D., Duncan Campbell, M.D., William J. Cassidy, M.D., Aaron L. Chapman, M.D., Don A. Cohoe, M.D., Ray S. Dixon, M.D., Clair L. Douglas, M.D., Edward F. Dowdle, M.D., Clarence H. Eisman, M.D., Ray L. Fellers, M.D. William Gramley, M.D., Charles W. Husband, M.D., Zeno L. Kaminski, M.D., Charles S. Kennedy, M.D., Hugh A. McFadyen, M.D., Edward J. O'Brien, M.D., Jacob R. Rupp, M.D., Rene J. St. Louis, M.D. Stelios N. Sakorraphos, M.D., Simon H. Sauter, M.D., Jesse G. Slaugenhaupt, M.D., Elisha J. Tamblyn, M.D., Delma F. Thomas, M.D., Harriet E. McLane, M.D.

(b) Eleven members to Retired Membership: (Oakland County) Burton M. Mitchell, M.D.; (Wayne) Roland M. Athay, M.D., Carl C. Birkelo, M.D., Harry G. Clark, M.D., Floyd B. Knapp, M.D., Arlington F. Lecklider, M.D., Walter H. Squires, M.D., Hugh Stalker, M.D., Henry B. Steinbach, M.D., Cleary N. Swanson, M.D., William A. Thompson, M.D.

(c) Fifty-eight members to Associate Membership: (Alpena) Jerry Miller, M.D.; (Chippewa-Mackinac) LeRoy A. Futterer, M.D.; (Hillsdale) William O. Michel, M.D.; (Gratiot County) LeRoy F. Von Lackum, M.D.; (Oakland) Juliette Seelye Karow, M.D.; (Washtenaw) John N. Bicknell, M.D., George E. Block, M.D., Fred G. Blum, Jr., M.D., Philip D. Brooks M.D., Donald C. Bullington, M.D., Charles W. Butler, Jr, M.D., C. William Castor, Jr., M.D., William A. Challener, III, M.D., George W. Cheek, Jr., M.D., Alton J. Coppridge M.D., William M. Cutler, M.D., James H. Geist, M.D., Robert I. Goldsmith, M.D., Carol E. Goodman, M.D., Frank H. Goodrich, M.D., Donald J. Holmes, M.D., Albert S. Jacknow, M.D., Robert S. Jampel, M.D., Edmund M. Krigbaum, M.D., Graydon A. Long, M.D., John C. Nixon M.D., Gerald A. O'Connor, M.D., Alden R. Parker, M.D., Prasanna K. Pati, M.D., Gus A. Raney, M.D., Melvin J. Reinhart, M.D., F. Dale Roth, M.D., Arthur S. Shufro, M.D., Carlson R. Speck, M.D., Donald Y. Stewart, M.D., Thomas P. Stratford, M.D., Emanuel Tanay, M.D., Ralph W. Theobald, M.D., Robert L. Timmons, M.D., John B. Tisserand, Jr., M.D., John S. Tytus, M.D., John D. Werley, M.D., Donald K. Williams, M.D., James H. Winkler, M.D., James A. Wood, M.D., William S. Wilson, M.D.; (Wayne) Donald R. Brock, M.D., Paul Dzul, M.D., David French, M.D., Eugene P. Frenkel, M.D., Alex Gaynor, M.D., Frank L. Hoagland, M.D., L. W. Hull, M.D., William V. Kyle, M.D., Charles West, M.D., John D. McKinnon, M.D., Donald R. Nielson, M.D., Melvin K. Pastorius, M.D.

Michigan State Medical Society

Ninety-second Annual Session

DIGEST OF PROCEEDINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING SESSION

September 23, 1957

The ninety-second annual session of the House of Delegates of the Michigan State Medical Society was held at the Pantlind Hotel, Grand Rapids, Michigan, on September 23-25, 1957, convened at 10:25 a.m., K. H. Johnson, M.D., Speaker of the House, presiding.

I. RECORD OF ATTENDANCE

Member-at-Large	*Meetings*					
(Immediate MSMS Past President)	*1st*	*2nd*	*3rd*	*4th*	*5th*	*6th*
Wm. S. Jones, M.D.	x	x	x	x	x	x
Honorary Member						
A. V. Wenger, M.D.	x	x	x	–	x	–
County and Delegate						
ALLEGAN						
L. F. Brown, M.D.	x	x	x	x	x	–
ALPENA-ALCONA-PRESQUE ISLE						
E. S. Parmenter, M.D.	x	x	x	x	x	x
BARRY						
A. B. Gwinn, M.D.	x	x	x	x	x	x
BAY-ARENAC-IOSCO						
D. A. Bowman, M.D.	x	x	x	x	x	–
O. J. Johnson, M.D.	x	x	x	x	x	x
BERRIEN						
Noel J. Hershey, M.D.	x	x	x	x	x	x
D. W. Thorup, M.D.	x	x	x	x	x	x
BRANCH						
R. J. Fraser, M.D.	x	x	x	x	–	x
CALHOUN						
Harvey C. Hansen, M.D.	x	x	x	x	x	x
James W. Hubly, M.D.	x	x	x	x	x	x
CASS						
S. L. Loupee, M.D.	x	x	x	x	–	–
CHIPPEWA-MACKINAC						
W. F. Mertaugh, M.D.	x	x	x	x	x	x
CLINTON						
Franklin W. Smith, M.D.	x	x	x	x	x	x
DELTA-SCHOOLCRAFT						
James R. Dehlin, M.D.	x	x	x	x	x	x
DICKINSON-IRON						
D. R. Smith, M.D.	x	x	x	x	x	x
EATON						
B. P. Brown, M.D.	x	x	x	x	x	x
GENESEE						
G. E. Anthony, M.D.	x	x	x	x	x	
F. W. Baske, M.D.	x	x	x	x	x	x
C. W. Colwell, M.D.	x	x	x	x	x	x
F. D. Johnson, M.D.	x	x	x	x	x	x
J. E. Livesay, M.D.	x	x	x	x	x	x
GOGEBIC						
J. E. McEnroe, M.D.	Not represented					
GRAND TRAVERSE-LEELANAU-BENZIE						
D. G. Pike, M.D.	x	x	x	x	x	x
GRATIOT-ISABELLA-CLARE						
E. S. Oldham, M.D.	x	x	x	x	x	x
HILLSDALE						
A. W. Strom, M.D.	x	x	x	x	x	x
HOUGHTON-BARAGA-KEWEENAW						
P. S. Sloan, M.D.	x	x	x	x	x	x
HURON						
C. W. Oakes, M.D.	x	x	x	x	x	x
INGHAM						
L. A. Drolett, M.D.	x	x	x	x	x	–
H. W. Harris, M.D.	x	x	x	x	x	x
F. L. Troost, MD	x	x	x	x	x	x
J M. Wellman, M.D.	x	x	x	x	x	x
IONIA-MONTCALM						
R. E. Rice, M.D.	x	–	x	x	x	x
JACKSON						
H. W. Porter, M.D.	x	x	x	x	x	–
W. A. Wickham, M.D.	x	x	x	x	x	x
KALAMAZOO						
Sherman E. Andrews, M.D.	x	x	x	x	x	–
Frederick C. Ryan, M.D.	x	x	x	x	x	x
Wm. A. Scott, M.D.	x	x	x	x	x	x
KENT						
F. S. Alfenito, M.D.	x	x	x	x	x	x
W. C. Beets, M.D.	x	x	x	x	x	x
J. T. Boet, M.D.	x	x	x	x	x	x
J. R. Brink, M.D.	x	x	x	x	x	x
F. M. Burroughs, Jr., M.D.	x	x	x	x	x	x
G. W. DeBoer, M.D.	x	x	x	x	x	x
R. A Rasmussen, M.D.	x	x	x	x	x	x
LAPEER						
D. J. O'Brien, M.D.	x	x	x	x	x	–
LENAWEE						
G. C. Wilson, M.D.	x	x	x	x	x	–
LIVINGSTON						
H. C. Hill, M.D.	x	x	x	x	–	x
LUCE						
D. C. Adams, M.D.	Not represented					
MACOMB						
Sydney Scher, M.D.	x	x	–	–	–	x
Edward G. Siegfried, M.D.	x	x	x	x	x	x
MANISTEE						
Robert R. Garneau, M.D.	x	x	x	x	x	x
MARQUETTE-ALGER						
A. S. Narotzky, M.D	x	x	x	x	x	x
MASON						
H. G. Bacon, M.D.	x	x	x	x	x	x
MECOSTA-OSCEOLA-LAKE						
Paul Ivkovich, M.D.	x	x	x	x	x	x
MENOMINEE						
J. R. Heidenreich, M.D.	x	x	x	x	x	x
MIDLAND						
Harold L. Gordon, M.D.	x	x	–	x	x	x
MONROE						
S. Newton Kelso, M.D.	x	x	x	x	x	–
MUSKEGON						
D. R. Boyd, M.D.	x	x	x	x	x	–
N. W. Scholle, M.D.	x	x	x	x	x	–
NEWAYGO						
J. Paul Klein, M.D.	x	x	x	x	x	x
NORTH CENTRAL						
L. F. Hayes, M.D.	x	x	x	x	x	x
NORTHERN MICHIGAN						
J. R. Rodger, M.D.	–	x	x	x	x	x
OAKLAND						
E. W. Bauer, M.D.	x	x	x	x	x	x
E. B. Cudney, M.D.	x	x	x	x	x	x
H. A. Furlong, M.D.	x	x	x	x	x	x
Paul T. Lahti, M.D.	x	x	x	x	x	x
John M. Markley, M.D.	x	x	x	x	x	x
P. E. Sutton, M.D.	x	x	x	x	x	x
W. J. Zimmerman, M.D.	x	x	x	x	x	x
OCEANA						
W. G. Robinson, M.D.	Not represented					
ONTONAGON						
W. F. Strong, M.D.	x	x	x	x	x	x
OTTAWA						
Otto van der Velde, M.D.	x	x	x	x	–	x
SAGINAW						
E. C. Galsterer, M.D.	x	x	x	x	x	x
J. P. Markey, M.D.	x	x	x	x	x	–
A. C. Stander, M.D.	x	x	x	x	x	x
SANILAC						
K. T. McGunegle, M.D.	x	x	x	x	x	–
SHIAWASSEE						
Claude L. Weston, M.D.	x	x	x	x	x	x
ST. CLAIR						
Joseph F. Beer, M.D.	x	x	x	x	x	x
ST. JOSEPH						
S. A. Fiegel, M.D.	x	x	x	x	x	x
TUSCOLA						
L. L. Savage, M.D.	x	x	x	x	x	x
VAN BUREN						
F. J. Loomis, M.D.	x	x	x	x	x	–

WASHTENAW						
Gerhard H. Bauer, M.D.	x	x	x	x	x	x
O. K. Engelke, M.D.	–	–	x	x	x	x
Harold F. Falls, M.D.	x	x	x	x	x	x
Theodore G. Kabza, M.D.	–	x	x	–	–	–
R. W. Teed, M.D.	x	x	x	x	x	x
V. M. Zerbi, M.D.	x	x	x	x	x	x
WEXFORD-MISSAUKEE						
Robert V. Daugherty, M.D.	x	x	x	x	x	x
WAYNE						
Sidney Adler, M.D.	x	x	x	x	–	–
Raphael Altman, M.D.	x	x	x	–	–	–
Warren W. Babcock, M.D.	x	x	x	x	x	x
Gaylord S. Bates, M.D.	x	x	x	x	x	x
Louis J. Bailey, M.D.	x	x	x	x	x	x
John G. Bielawski, M.D.	x	x	x	x	x	x
James B. Blodgett, M.D.	x	x	x	x	x	x
Wm. L. Brosius, M.D.	x	x	x	x	x	x
Clarence L. Candler, M.D.	x	x	x	x	x	–
Wm. S. Carpenter, M.D.	x	x	x	x	–	–
Ralph R. Cooper, M.D.	x	x	x	x	x	–
Russell T. Costello, M.D.	x	x	x	x	x	–
Milton A. Darling, M.D.	x	x	x	x	x	x
Harry F. Dibble, M.D.	x	x	x	x	–	–
Laurence S. Fallis, M.D.	x	x	x	x	x	–
Harold B. Fenech, M.D.	x	x	x	x	x	x
Edwin H. Fenton, M.D.	x	x	x	x	x	x
Russell F. Fenton, M.D.	x	x	x	x	x	x
George S. Fisher, M.D.	x	x	x	x	x	x
James D. Fryfogle, M.D.	x	x	x	x	–	–
Perry C. Gittins, M.D.	x	x	x	x	x	x
Clyde K. Hasley, M.D.	x	x	x	x	x	x
Leslie T. Henderson, M.D.	x	x	x	x	x	x
Joseph Hickey, M.D.	x	x	x	x	x	x
Louis Jaffe, M.D.	x	x	x	x	x	x
Joseph A. Kasper, M.D.	x	x	x	x	x	x
Earl G. Krieg, M.D.	x	x	x	x	–	–
Edward H. Lauppe, M.D.	x	x	x	x	x	x
Max L. Lichter, M.D.	x	x	x	x	x	x
E. C. Long, M.D.	x	x	x	x	x	x
Robert C. Lytle, M.D.	–	x	x	x	x	x
Robert L. Novy, M.D.	x	x	x	x	x	x
Eugene A. Osius, M.D.	x	x	x	x	x	x
C. I. Owen, M.D.	x	x	x	x	x	x
Alice E. Palmer, M.D.	x	x	x	x	x	–
Ralph H. Pino, M.D.	x	x	x	x	x	x
Alvin E. Price, M.D.	x	x	x	x	–	–
William S. Reveno, M.D.	x	x	x	x	–	–
Francis P. Rhoades, M.D.	x	x	x	x	x	x
Albert D. Ruedemann, Sr., M.D.	x	x	x	x	x	–
Charles W. Sellers, M.D.	x	x	x	x	x	–
William L. Sherman, M.D.	x	x	x	x	x	x
Carl J. Sprunk, M.D.	x	x	x	x	–	x
Claire L. Straith, M.D.	x	x	x	x	–	x
David I. Sugar, M.D.	x	x	x	x	–	–
Roger V. Walker, M.D.	x	x	x	x	x	x
Milton R. Weed, M.D.	x	x	x	x	x	x
Robert K. Whiteley, M.D.	x	x	x	x	–	–
Joseph A. Witter, M.D.	x	x	x	x	x	x
Donald C. Young, M.D.	x	x	x	x	x	–

IN MEMORIAM

Each year at this time we announce the names of former members of this House who have passed away during the previous year.

Allegan County: Olin H. Stuck, M.D., Otsego.

Saginaw County: J. W. MacMeekin, M.D., Saginaw.

In addition, fifty-nine members of the Michigan State Medical Society have passed away since last we met. The Speaker would like the House to stand for a moment in silence.

II. PRESIDENT'S ADDRESS

By Arch Walls, M.D.

This week I am bowing out as the President of our State Medical Society. Although the President's job is sometimes thought of as that of a figurehead, it is an honor, and I have tried to live up to your expectations and be a good one. At times it has been hectic, tiring and a bit discouraging; then I would think of the many fine men who stood by me—sincere good doctors whom I would never have known as close friends had I not held this position. Then I knew the hours away from my home and my practice had borne fruit for me.

Certainly there is no financial gain—there is nothing tangible to hold in one's hand; it is something far greater than that. Only a man who has sacrificed his own desires to help make his profession a better one can understand the personal satisfaction derived.

I wish to thank all the men in our Society who have worked with me to make my leadership a success. Most of all, I wish to express my gratitude to the hard-working members of The Council. These men need, and have, a high degree of unselfishness, a feeling of indebtedness to their profession, and the desire to give of themselves in return.

These qualities are what it takes to make good members of our Council. Our progress is measured by the policies formulated by our Council. Thus, I feel that only top men can plan our future advances well. There is no room for petty bickering, no time for personal gain. Only big men—and I don't mean physically—can handle the problems. We have had high-caliber men in the past. Let's keep the quality high.

This past year we have tried to extend our open door policy. We have it open now, and I hope it will swing wide to accomplish far more. This year we learned to know men of other professions. We liked them, understood their problems better, tried to find out what they didn't like about us, and why. It was enlightening, to say the least.

We only laid the foundation this year. I hope we can build a strong bond between our medical profession with all the others so that as problems arise we can sit down with them and work things out agreeably and well. We need their help, and I have learned that they would like ours.

We have accomplished quite a bit at our State meetings, and they have been beneficial to all of us. However, I don't believe there has been enough effort made by all of us, when we return to our county societies and our hospital staffs, to enlighten other doctors who have not attended our State meetings. If we would spend a little time to tell them what the State Society has tried to do, the problems that confronted us, there would be more interest aroused—a better understanding achieved.

I take great pride in the knowledge that Michigan doctors received national recognition in the polio program. The way it started out, it could have been a debacle; but it turned out to be a triumph because our entire profession throughout the State made it a success. That united effort proved to me that, acting together, we could accomplish almost anything.

There are vitally important things for us to do. For example, the mental health situation is desperately in need of a thorough study by us. We have just scratched the surface of that one; but, as in the other problems, if the whole medical profession will co-operate we should be able to find a better way to take care of this number one problem.

Sometimes, with all our professional duties and problems, we as doctors forget that we also have duties and responsibilities as citizens. We become very unhappy with conditions affecting our lives outside of medicine. But do we do much about it? I think not. Doctors are well educated and, as a whole, intelligent, aggressive men. Some of our ability certainly can be used to advance new laws and to improve our government in order to make this a better state in which to live.

I feel that we have fallen far short in our contributions as citizens. It is easy for us to say, "I haven't the time; let others who aren't so busy do the job," but this is only a poor excuse made by a poor citizen. As a State Society we have great potential to wield influence to the betterment of this great State.

In finishing, let me tell you again how fine you have all been in your efforts to make my job easier. I deeply appreciate your friendship, and I hope that down through the years we can continue to work together to make this the greatest medical society in the country. [*Applause*]

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Dr. Walls' address was referred to the Reference Committee on Officers' Reports.

III. PRESIDENT-ELECT'S ADDRESS

By George W. Slagle, M.D.

As we begin our 92nd annual session today and start down the road of the coming year in our Society's progress, I would like to pause a few moments and reflect on what has transpired this past year.

As your President-elect it was my good fortune to be an observer and a part of many gatherings that were held in the best interests of our Society. This has been a big year for all of us, as reports from our different committees, The Council, our officers, and the Opinion Survey on Prepaid Medical Care will bring forth. It may well go down in history as a pivotal year in the development of our philosophy of how best to supply the finest medical care for the public.

Progress has been made. Long steps forward have been taken. Much more needs to be done. The immediate future is the time that our findings and decisions will need to be implemented. Other problems and crises undoubtedly will arise and will have to be solved. None of us carries a crystal ball—and even if we did, we wouldn't know how to read it; hence, we cannot accurately predict how the coming year will evolve. However, by reviewing and appraising what has been done this past year—which is exactly what this House will do during these two days—basic concepts can be formed and a projected course of action laid down. It is important that this be done, and it is doubly important that our membership be united behind the policies that this House declares itself in favor of.

Hundreds of you and your confreres have given liberally of your time and unstintingly of your efforts in the past to make our Society what it is—one that is held in high esteem throughout this country, one of which we can justly be proud. I know that the same will be evident in the future. The letters I have received from many of you, pledging your support and co-operation in the year ahead, have been soul-warming and give me the strength to look forward to the challenge with hope and confidence rather than with fear and trepidation.

We are fortunate in that we have sincere, intelligent and dedicated men of our profession as members of our Council and of this House of Delegates. Your officers in the past have reflected your keen judgment in their selection, and I am sure the future will not be different.

Through my association with much wiser heads than my own this past year, and from observing progress made, and from watching trends develop, I feel that these next years will be important ones to our profession. If so, what can our Society do to see that the best interests of the public are served?

Continuation of the open door policy.—The so-called "open door policy" of the Michigan State Medical Society, as so aptly proposed last year by our fine President, Dr. Walls, has met with success and must be a continuous policy of this organization. Meetings with representatives of interested groups, labor, management, farmers, government, and so on, have been held by your officers and committees, and much good and mutual respect and understanding has resulted. This we should carry on.

Our opinion survey approach to the public is an extension of this policy. We might term it the "research policy." It is our recommendation that necessary surveys of this nature be repeated in the future as times dictate and, further, that we expand our research activities through related studies in the health and insurance fields. We feel that this is an obligation of ours to the public. Also, we feel that a large majority of our members agree that this is true and will be willing to support it both actively and financially.

The days of being passive in these problems is past. We must assume an active leadership! Who knows best the medical needs of the public? The doctors of medicine! So, we are, and must continue to be, partners with the people in providing the methods for supplying such care.

Ethics.—Another aspect of seeing that the people receive the best of medical care falls within the field of ethics. Ethics, or codes of ethics, are formulated for the protection of someone. I want to emphasize that medical ethics are for the protection of the public, for each individual member of our great nation, and not for any special group, clique or segment of the population. In this discussion I refer to only one part of our ethics; but many of us feel that it is actually the heart and soul of our basic concept of the philosophy of medicine that has been our heritage throughout the years, namely, the free choice of physician.

Our profession must become united in our fight to preserve this basic right of the individual to choose his own physician. We must fight for this, not against something. With this free choice of physician naturally must go the right of the physician to choose whom he will serve; but once the patient is accepted by the doctor, the doctor must discharge his obligation. The right of the physician to treat that patient in the manner that his training and best judgment dictates must not be lost. Any endeavor by a third party to disturb this basic concept must be actively condemned.

If wishing to maintain status quo on this problem is "against progress," then I am willing to stand up and be counted and to fight for that fundamental concept. In certain areas of our country plans with third-party intervention abridging this basic right have been in operation for several years. Others are being planned.

The problem is so important throughout this country that at the June meeting of the American Medical Association in New York City, five resolutions dealing with it were introduced on the floor of the House of Delegates. They urged that participation of doctors of medicine in any of these third-party plans be considered unethical. A modified concept was approved.

This House of Delegates, and our Society, must be mindful of our responsibilities here and must give it careful consideration now and through the months to come. We must not be hesitant to fight for what we think is right.

Association of professions.—The past few years have brought to the attention of many of us that if social evolution continues as it has, the time may come when professions, as such, may cease to exist. If more and more supervision and direct control over our profession becomes the rule, we will then become trades or guilds. A profession now has the right to set up its own standards of quality, to choose when and how they will offer services, to whom they will make these services available, and to set and collect their fees.

It seems to me there are many areas at times where the public would be better served if there were an active organization of the various professions made up of duly elected representatives from the individual professions. It might be considered as a "union"—spelled with a small "u"—of the professions.

In a general sense, the medical profession is a union.

We are an association of people who are bound together for a purpose—for the common welfare and benefit of our patients—to give service and to advance the science of medicine. Is there any reason why other similar unions with similar high and unselfish aims should not join with us to solve mutual problems involving professional rights?

While we have been preoccupied with the scientific endeavors of our organizations, we have not thought about banding together as the units within industry and units within labor have banded themselves together across the board. Such a union of professional groups or persons could do much to protect professionalism and all of the many values which professionalism has.

Many problems of importance to the professions as a group might well be solved more easily and to the best interests of the state and community. I believe that if the Medical Society were to suggest such a plan to the other professions, and to invite open discussion, it might well become consummated.

Appraisal of our state committees.—A New York consulting firm recently made a survey of medical society activities, including committee structure. Its report indicated that the Michigan State Medical Society, among all the states, had the highest number of committees (sixty-one) not including numerous subcommittees. This was forcibly brought to my attention in recent weeks while making appointments to certain of these committees. The report suggested that more efficiency would result from a better integration of our State Society committees.

MSMS has three types of committees: (1) Committees of the House of Delegates, appointed by the Speaker; (2) committees of the Michigan State Medical Society, appointed by the President; (3) committees of The Council, appointed by the Council Chairman. My remarks here refer only to the second and third groups—committees of the MSMS and committees of The Council.

Obviously, duplication and overlapping of activities and studies have grown (like Topsy) among our sixty-one committees. For example, we have five committees dealing generally with Michigan Medical Service and with fee schedules—and that does not include two committees on these subjects appointed by the 1956 House of Delegates. Efficiency suggests that one, or perhaps two at the most, should be charged with these responsibilities. Another example is the Permanent Conference Committee (which handles liaison with hospitals and nurses) and the overlapping Hospital Relations Committee.

I will spare you other illustrations, but will present to the Reference Committee a list of our Michigan State Medical Society and Council committees and my thoughts on the subject.

Suffice it to say, our committee structure needs some serious study to make it more modern and efficient. Therefore, to conserve the valuable time of these hundreds of our self-sacrificing members who serve on committees, and to save expense to the Society, I respectfully offer the following recommendation:

(This may seem incongruous, but sometimes one has to use an "antidote of the same" to correct an unsatisfactory condition.) I recommend that the Chairman of The Council be instructed by the House of Delegates to appoint a Special Evaluation Committee to survey our entire committee structure with a view to streamlining it, this Evaluation Committee to render a final report and recommendations to the House of Delegates in September, 1958; and that the Speaker, the incoming President-elect, and The Council Chairman (who are responsible for the appointment of committees) be named among the members of this Special Evaluation Committee.

In conclusion, I wish to reemphasize that by learning from the past we can look to the future with hope and confidence. You have one of the finest society organizations in the country, one of which we all can be justly proud. It is not a one-man or even a small-group affair, but one that is the result of the combined effort of each of us, of each of our 6,400 members. It must remain that way.

With the continued help of all, the Michigan State Medical Society will remain a leader in the profession, and the State and nation will benefit thereby.

MSMS COMMITTEE STRUCTURE

POSTGRADUATE MEDICAL EDUCATION

Postgraduate Medical Education
Scientific Radio
Courses in Medical Economics and Ethics

PREVENTIVE MEDICINE

Preventive Medicine
Rheumatic Fever Control
Cancer Control
Maternal Health
Venereal Disease
Tuberculosis
Mental Health
Child Welfare
Geriatrics
Industrial Health
Iodized Salt
Prevention of Highway Accidents
National Defense
Rural Medical Service
Blood Banks
Periodic Health Appraisal

*[Committees in italics are committees of The Council. All others are committees of MSMS.]

PUBLIC RELATIONS

Public Relations
Legislative
Advisory to Woman's Auxiliary
Advisory to Michigan State Medical Assistants Society
Beaumont Memorial
Liaison with Univ. of Michigan
Liaison with Mich. St. Pharm. Assn.
Awards
Liaison with Veterans
Liaison with State Bar
Liaison with St. Bd. of Reg. in Medicine
Liaison with St. Exec. Office
WCMS Film
Liaison to Mich. Psy.
Healing Arts Study
Permanent Conf. Comm.

MEDICAL ECONOMICS

Study Comm. on Fee Schedules for MMS [Hull]
Arbitration
Ins. Studies
Mich. Med. Service [Slagle]
Liaison with MMS [Wellman]
Hospital Relations
M.D. Placement
Basic Science Act
Periodic Health Exams in Hospitals
Big Look (and Site)
V.A. Home Town Med. Care Program
Uniform Fee Schedule for Govt. Agencies
Package Arrangements

MEDIATION, ETHICS AND GRIEVANCE

Ethics
Mediation
Study of M-E-G

*[Committees in italics are committees of The Council. All others are committees of MSMS.]

HOUSE OF DELEGATES COMMITTEES

Committee on Use of the Word "Clinic"
Committee to Study Comprehensive Prepaid Plans
Permanent Advisory Committee on Fees

Reference Committees on: Officers' Reports; Reports of The Council; Reports of Standing Committees; Reports of Special Committees; Constitution and Bylaws; Resolutions; Rules and Order of Business; Legislation and Public Relations; Hygiene and Public Health; Medical Service and Prepayment Insurance; Miscellaneous Business; Special Memberships; National Defense and Disaster Planning; Executive Session.

The six basic categories indicated above could be called "commissions"; they could be appointed to stimulate and integrate action of the committees in their particular category. They could be composed of an appointed chairman plus the chairmen of each of the committees in that category (as has been the successful experience for years of the MSMS Preventive Medicine Committee); with the privilege to the appointing officer to add additional members as need be.

Further, the Special Evaluation Committee may wish to consider that all committeemen be appointed for a specific number of years—with a time limit for service

on a particular committee. Thus, men who show great ability would be moved up, and their places on committees would be taken by new talent with new ideas and new drive.

Subcommittees.—Any committee would have the privilege of appointing task groups to accomplish specific purposes.

In a word, MSMS would have five basic commissions, as many committees under the commissions as required, and task groups under the committees for specific one-punch projects.

* * *

Dr. Slagle's address was referred to the Reference Committee on Officers' Reports.

THE SPEAKER: Dr. C. I. Owen, Chairman of the Committee to Study Comprehensive Prepaid Insurance Plans, a Committee that was authorized by resolution of the House of Delegates last year and appointed by the Speaker, are you ready to report?

IV. REPORT OF COMMITTEE TO STUDY COMPREHENSIVE PREPAID INSURANCE PLANS

C. I. OWEN, M.D. (Wayne): All of you have received a copy of the report ordered by the original resolution, dated July 15. The report was made about July 1 and was agreed to unanimously by the various members of the Committee, but I believe everyone reserves the right to change their minds if they wish. Therefore, it may not be unanimous.

I wish to thank sincerely the members of the Committee, because they worked diligently and well, sometimes too diligently for the good of their own practice. I wish to thank Dr. DeBusk of Grace Hospital, who furnished the stenographic help and the mimeographing services that prepared all of these reports. We also arranged to meet and talk with members of the hospital group.

I also wish to thank Mr. Jay Ketchum and his staff, who were very free with their time and help. I don't know what we would have done without Jay.

* * *

Your Committee, appointed by the Speaker, has conducted the study as ordered by the House and begs to submit this report which embodies a brief exposition of the situation, some of its problems and a number of specific proposals.

In our deliberations many people were consulted, such as officials of industry, labor unions, hospitals and Blue Shield. We were surprised to learn that many physicians did not understand the basic difference between the commercial carriers and Blue Shield (except that Blue Shield is run by the doctors) nor the difference between an indemnity type of insurance and a service contract. We learned that few of our MSMS members realize how easy it would be for a large corporation to make "rough sledding" for Blue Shield by using other insurance plans to cover its employes, nor how easy it would be for a large union to seriously impair our organization's service to the people.

Early in our deliberations we found that the cost (and increasing cost) of hospitalization and its insurance programs constitutes a major problem. Since hospitals occupy a very important and integral part of our existence, it became impossible to think of comprehensive prepaid medical care without considering in the same breath hospitalization insurance and its cost.

Many people, including some of our own members, fail to distinguish between hospital and medical care insurance. Everyone, including Uncle Sam as a tax collector, correctly includes hospitalization costs as a part of their total medical expense. Most insurance packages include both hospital and medical care as a co-ordinated unit. If packages are more or less restricted, the hospital feature is rarely left out. We learned that about 75 per cent of all patients entering hospitals for acute illness have some form of insurance paying some or all of their hospital cost.

This, of course, indicates excellent progress and has allowed many people to have better and more medical care. But it has produced some rather serious problems, the principal one being the persistent gradual increase in hospital costs and rates, reflecting itself in a gradual increase in Blue Cross premiums. The latter has reached the point of serious consumer resistance. One group we interviewed informed us that if there should be another increase in the near future a substantial number of their members would withdraw. At all levels and from many people, many complaints were heard and much information gathered about the misuses and abuses of both hospital and medical insurance.

It should be recalled that both Blue Shield and Blue Cross were developed originally to alleviate catastrophic costs to the patients, to allow more and better medical care and hospitalization, to stem the onslaught of government medicine and to assure payments to doctors and hospitals. All of these aims have been accomplished to a great degree but not without the development of two problems: (1) over hospitalization and (2) over utilization, which eventually could help put the costs of both medical and hospital care beyond the reach of the average consumer. These arise from four sources as follows: (a) the patient who insists on staying longer than necessary for his own or his family's convenience; (b) the hospital whose prime interest is to keep its beds occupied at a guaranteed income; (c) pressure groups who curry favor with their constituents; and (d) doctors who succumb to unreasonable demands. The danger is all the more obvious when one realizes how many features of the original Murray Wagner Dingell Bill have been enacted into law. One of our consultants frankly estimated that the cost of hospital insurance could be reduced 25 per cent if all of the over-uses could be eliminated.

In Michigan there is no legal definition of what constitutes a hospital. There is no line drawn between nursing homes, medical hotels, a home with a few rooms and an operating room and a hospital where full facilities are available. Neither are there any laws which regulate, classify or control hospitals (except for maternity care). This results in a real problem from the standpoint of insurance coverage, as well as in some rather poor service to patients. This situation alone deserves great consideration and attention.

Thus, some of our recommendations will concern hospitals and our relationship with them. One of our recommendations referable to increased coverage by medical insurance will help reduce some of the hospital utilization.

One of the most serious and unfair factors that we studied arose in the comparisons of participating and non-participating physicians in the Blue Shield program. The participating physician is the backbone of the entire program (and if no one participated it could not exist). He agrees to abide by certain rules concerning fees and fee schedules. The nonparticipating physicians are termed by some as "free riders." They agree to nothing, follow no rules and have many of their fees collected by Blue Shield. We think this is very unjust and have a recommendation which would be helpful in correcting the condition.

The question of extra fees over and above the Blue Shield schedule is a serious and annoying one to many people and constitutes a major problem. The average policyholder does not understand his contract and nearly always expects more than the contract provides. An extra charge above the Blue Shield contract frequently begets more ill-will than it could possibly be worth. Unless there is an advance understanding, the patient is apt to be annoyed and distrustful. On the other hand, physicians often think the fee sched-

ules are unrealistic and are upset when extra fees are not available or forthcoming. A frank discussion in advance with the patient will prevent most complaints.

We were told by those who originally worked out the fee schedule that it was designed as an average and not as a minimum or maximum. In usage it has proved to be the minimum. It must be remembered by everyone that a great advantage in fee collection results from Blue Shield. By record, Blue Shield fees are collected 100 per cent. Who can match this when patients are billed directly? This serves to emphasize the great value of a service contract versus an indemnity one. Hence, there should be some advantage to those who participate.

There was some discussion about income limits and extra charges on the basis of income higher than the contract designations. There appears to be no standard method for determining family income, especially when more than one member is working. No satisfactory method exists for determining the value of a farmer's income that derives from home consumption of his own products.

There was some discussion about two small but important segments of our populace: (1) indigents and (2) aged people, not covered by any program at the present time. We have a recommendation in this regard.

Recommendations

1. That Michigan Medical Service be continued as a voluntary pre-paid service benefit plan.

2. That nonparticipating physicians collect their fees directly from the patient and that the patient be reimbursed by Michigan Medical Service as per fee schedule.

3. That a broad coverage medical service program be developed by Michigan Medical Service to cover those in advanced years and indigents. This might require contracts with welfare and relief agencies but would be extremely valuable in the preservation of the free choice of physician and in maintaining good physician-patient relationship.

4. That Michigan Medical Service benefits be extended at this time to include:

   (a) Office surgery.
   (b) Diagnostic x-ray on both an in- and outpatient basis.
   (c) Diagnostic laboratory procedures on both an in- and outpatient basis.
   (d) Therapeutic x-ray and radium.
   (e) Physiotherapy on both an in- and outpatient basis.

This contract would, by necessity, carry with it appropriate deductible and co-insurance features, probably some ceiling and strict definitions. There would, of necessity, be specific designations of tests and procedures covered.

5. That certain contracts be made immediately available and sold to groups with 75-80 per cent coverage. Studies and figures have been made by Michigan Medical Service Management and are complete.

   (a) The present basic contract, $2,500-$5,000 and $6,000 be retained for all subscribers.
   (b) Full coverage—home, office, hospital—a complete service be offered.
   (c) An extended service to include outpatient and office surgery; diagnosis, including laboratory procedures, EKG, BMR, EEG, heart and blood; consultations; diagnostic and therapeutic x-ray and radium; physical medicine; anesthesia and assistance in certain operations.
   (d) All of these services and especially Numbers 2 and 3 could be offered as $25.00 and $50.00 deductible, co-insurance or full pay.

This offering would meet the ideas expressed by every critic and each group would have unlimited choice, to suit its own needs or desires.

6. That a joint study committee of the House of Delegates of the MSMS and the Michigan Hospital Association be established, whose specific duty it shall be to develop on a state-wide basis, a program of hospital classification, control and accreditation to the end that proper and just insurance relationships can be worked out.

7. That there be created in each hospital, a committee of the staff known as insurance audit and control committees, whose duties shall be as follows:

   (a) To study prepaid medical insurance plans now existing.
   (b) To study methods whereby economies may be effected in these plans.
   (c) To present to their constituents, through a series of lectures, publications and word-of mouth discussions, the facts that emphasize the importance of avoiding overuse and misuse of hospital and medical care facilities.

8. That State Medical Society Insurance Audit and Control Committees be organized on a regional basis throughout the State to work with Michigan Medical Service and Michigan Hospital Service in the study and control of the misuse and abuse of medical and hospital services.

9. That a more definite basis be defined and a uniform method used for the determination of salary limits and family income in relation to Michigan Medical Service contracts. This is especially applicable in families in which there is more than one employed worker and in estimating the value of food grown for home consumption by a farmer.

10. That we go on record as unalterably opposed to any and all forms of closed panel practice. That we further go on record that the choice of a closed panel is not the freedom of choice of a physician.

11. That we, as individual physicians and as the Michigan State Medical Society, pledge ourselves to continue to fight and work for the continued freedom of the practice of medicine and of the free choice of physician by every patient.

Respectfully submitted,
CLARENCE I. OWEN, M.D., *Chairman*
JOSEPH F. BEER, M.D.
JOHN E. HAUSER, M.D.
H. C. HILL, M.D.
EARL G. KRIEG, M.D.
MAX L. LICHTER, M.D.
KENNETH H. JOHNSON, M.D., *Ex Officio*
WILFRID HAUGHEY, M.D., *Advisory*
(at request of Chairman)

* * *

This report was referred to the Reference Committee on Medical Service and Prepayment Insurance.

V. REPORT OF MSMS-SPONSORED OPINION STUDY

THE SPEAKER: This is a very important moment in the history of the Michigan State Medical Society. We are about to present some information which may change your ideas and philosophies of medical insurance protection, and it certainly will have a far-reaching effect on many people in the State of Michigan.

Up to this point many of us have been dealing with opinions on medical insurance. Now we have the opportunity to deal with facts.

Last April 27 you authorized a study which, in broad general terms, would seek three types of information:

1. What medical services do people want covered by medical payment plans, and what do they feel is the order of priority for these services?

2. How much will people be willing to budget for

these services, and which of the services are they most willing to pay for?

3. What do doctors want from any medical insurance plan?

The medical profession felt that such a study would make a definite contribution to the public interest, so the Michigan State Medical Society joined forces with the Michigan Health Council to carry it out.

It looked like a big project, and, as it turned out, it was a terrific task. I cannot adequately describe nor emphasize too much the hard work that was done by the staff of the Michigan Society and the Health Council. Because of their diligent efforts, we are able to report the results of that study today.

First of all, however, I would like to point out that every step of the study was reviewed by the Survey Committee, which was actually the Executive Committee of The Council. In addition, the report of the results of the study has been approved by the full Council.

Three speakers are going to make this presentation today. I would like to point out that they will be *reporting;* they are not expressing personal opinions. What they have to say are the accurate reflections of the thinking of The Council and of the returns of the study.

The first speaker in this presentation is Dr. J. J. Lightbody, of Detroit. He will bring us up-to-date on what has happened since last April. At this time it gives me a great deal of pleasure to present the Vice Speaker of the House of Delegates of the Michigan State Medical Society, Dr. J. J. Lightbody.

J. J. Lightbody, *M.D.* (Wayne): It is a distinct pleasure and honor for me to take part in this important occasion. The past five months have been extremely busy ones for the committees that have been concerned with this comprehensive opinion survey study. To my knowledge, never before has a study of this scope been authorized and completed on such a fast time schedule. I also would like to thank those MD's who gave their valuable time to this strenuous activity, and extend a special vote of thanks to the executive staff and office staff of the Michigan State Medical Society and the Michigan Health Council for their outstanding work in bringing the results to you today, under the direction of Mr. Hugh Brenneman, Survey Director.

This presentation today will be in three parts and will accomplish three things: First, it will bring everyone up-to-date on why and how the study was conducted. Second, we will report the actual results of the survey. Third, we will summarize and conclude and place the report in your hands for proper disposition.

Much of this survey material is extremely complex; however; because all members of the House of Delegates want to take back information on this study to their respective county medical societies, we have made every effort to give you the facts arranged in the simplest possible form. At the same time our distinguished guests will want to interpret the survey to their respective organizations—or, in the case of the science writers assembled, they will want to interpret the information for their readers.

So, to help all of you, we have prepared a kit of materials which will be distributed immediately after this morning session adjourns. The science writers and others may obtain additional information in the press room if they so desire.

Now let us consider for a few minutes what has happened since the House of Delegates authorized the Opinion Study on Prepaid Medical Care Coverage in Michigan at the special session on April 27 of this year.

For a long time we have known that there had to be some changes made in the medical care plans and health insurance coverage now being offered in our State. Since most citizens in Michigan have some type of prepaid medical insurance, any changes made in policies and contracts would naturally affect these people directly.

Who, then, should decide what changes would be made? Should we listen to what the leaders of pressure groups had to say? Should we institute these changes between ourselves? Or, should we ask the people of Michigan who participate in these plans what these changes should be?

It was felt that since the medical profession and the people are partners in any plan or system of medical care, both the doctors and the people should have an opportunity to state their views about what medical-surgical services should be offered. So, we went directly to the people to find out what they wanted and what they were willing to pay for these services.

To find this out, an extensive State-wide study was carried out jointly by the Michigan State Medical Society and the Michigan Health Council. It was one of the biggest public opionion samplings of its type ever undertaken in Michigan or in the nation. It was a survey that was urgently needed. The House of Delegates felt the need because voluntary prepaid medical and surgical care plans have long been the target of leaders of various pressure and special interest groups. Many of such groups have pressed for revisions which are invariably offered as the panacea that will cure all real and imaginary ills of health insurance.

The *Detroit Times* commented on the need for such a survey in an editorial on July 14, 1957. I quote:

> "It's clear enough that strong public sentiment favors putting more medical care on a permanent monthly basis. But how far should this go? There is a difference between wishful thinking and hard-headed preference. Naturally, we all would like to have a plan that would include everything we ever might want—at a modest price. The problem here is to find out what people really want, in view of the inescapable fact that whatever we get has to be paid for."

So, in answering a definite need for the study, the Michigan State Medical Society and the Michigan Health Council joined forces to carry it out.

The study was conducted as scientifically as possible to gain an accurate cross-section of opinion. We called in top-notch sociologists and research experts as consultants. Plans were drafted immediately after the April 27 meeting, and were reviewed and adopted on May 15—and the survey began.

The Michigan Health Council co-operated in making the mail survey. As many of you know, this organization is a nonprofit, educational institution which has a membership of many different associations having a primary interest in health. A total of 55,169 persons in Michigan received this Michigan Health Council questionnaire, which was distributed on a county-by-county percentage population basis.

The questionnaire asked people about their preference in medical insurance plans, what benefits they would like to add or eliminate, and how much they would be willing to pay for any additional benefits. Information was obtained about the person's age, his income, the size of the community where he lives, his occupation, and his membership in organizations such as farm groups, labor unions or professional societies. In this way the study would show how the city people think, how the rural folks think, and how people with different incomes feel, and how the people in professional or occupational organizations react to prepaid medical care coverage plans.

You might think that the 55,000 mail questionnaires distributed by the Michigan Health Council would be sufficient to develop a trend in thinking; but we didn't stop there. Two Michigan newspapers—the *Detroit Sunday Times,* with a circulation of 500,000 and the *Lansing State Journal,* with a circulation of 68,000—published the questionnaires in full so that their readers could voice opinions as well.

The people of Michigan did more than just check the boxes and write in a few words. Many of them sent

lengthy letters with illuminating comments on what they think of the present plan of medical protection. Naturally, some of the opinions expressed were merely an opportunity to sound off on some of their pet peeves, but the great majority of the comments were well-thought-out messages of personal experiences.

For purposes of easier identification, we called this part of the study the Survey of Consumer Opinion on Medical Insurance Protection, or the mail survey. July 31 was selected as the cut-off date, after which no more mail questionnaires would be tabulated. The survey went out during the first week of July so that people had sufficient time to return them if they were interested. The response to this survey was excellent. Fully 15 per cent were returned by the cut-off date, and returns kept pouring in even after July 31. Tabulation of this survey was begun August 1.

A second questionnaire was mailed to Michigan M.D.'s by the Michigan State Medical Society. This special Doctor Opinion Survey was more technical in nature than the questionnaire sent out by the Michigan Health Council. It covered such things as the administration of major medical and surgical prepayment plans and health insurance policies offered in Michigan, subscriber contract arrangements, and methods of payment. Every doctor in this room who is a member of the MSMS was sent such a questionnaire. It was called the Survey of Doctor Opinion on Prepaid Medical Care Plans. Response to this questionnaire was excellent. There was a 38.5 per cent return. Normally, our survey analysts tell us, a return of 10 per cent is considered average.

Many of the doctors added lengthy comments about how they felt about Michigan Medical Service, Many of these comments have been recorded and will be published so that you can see this cross-section of opinion.

At the same time that these mail surveys were going on, personal interviews were being conducted throughout Michigan by the Market Opinion Research Company of Detroit. A group of 1,000 people representing a cross-section of the Michigan adult population was selected from typical counties, cities and rural areas, to include people in all occupational, age and income groups. Although these interviews followed the general lines of the mail survey, they were much more detailed.

The mail questionnaires, along with the personal interviews, answered the questions we wanted to know about what people wanted in medical care plans, what they were willing to budget for these services, and what the doctors expected from the plans. In addition, we also gathered a great deal of existing data from surveys made previously in other areas of the United States on the same basic questions. This information was compiled and is made a part of this report, along with the Michigan opinion survey facts.

After the July 31 deadline had passed, the tabulation began. First, all write-in answers were coded so that these answers could be incorporated with the other coded answers on the balance of the questionnaire and, in turn, tabulated by the Service Bureau Corporation, using IBM machines. This tabulation took approximately six weeks to complete.

That, in general, was the way the survey was conducted. Beginning with the authorization in April, we hired consultants to help us prepare the questions; then the various surveys were made, and finally they were tabulated. Up to this point it was conducted very much like any other survey.

However, our study was unique in many ways. As you can see, for one thing it was operated on almost a supersonic time schedule. It is not unusual for a comprehensive study of this type to take a year or more to complete.

From the decision to launch the survey to the report of the results, it was completed in only four months and one week.

The questionnaire was not sent to select groups; on the contrary, every effort was made to get as wide a distribution as possible.

In a special effort to get the questionnaire into the hands of people who work in Michigan industry, municipal government, merchandising and sales organizations, or trade organizations, personal letters were written to employers, with a copy of the questionnaire enclosed. The employers were asked to spread the word in their publications and request additional copies of the questionnaire for wide distribution among their workers. The response to this was gratifying. In fact, even now, late in September, we are still receiving requests for questionnaires.

The study was unusual in another way, in that an extensive publicity campaign was carried out all the time the project was in the works. This included radio, television and newspaper coverage.

Usually there is little publicity about a survey until the results are announced. In this case, however, we attracted public attention to the study so that the people would know about it and would understand the reason for the study, and would respond with a maximum return of the questionnaires.

So, the Michigan Health Council and the Michigan State Medical Society conducted a rapid, accurate, well-publicized study on medical care with an unusually large number of people. You delegates authorized the study, and it has been carried out.

As doctors, when dealing with disease we try to make an accurate diagnosis, then decide what to do after checking the facts. This same principle was applied in the diagnosis of what people want in medical care plans. The results of this opinion survey may not lead the way to a new miracle drug on the insurance market, or give everyone everything they want in a medical-surgical program, but at least, from this point on, we will be dealing with facts, not fiction or guess-work, because the people of the State of Michigan have spoken.

THE SPEAKER: It gives me a great deal of pleasure now to present to you Mr. Hugh Brenneman. I know how hard Hugh has worked, and I know how hard his staff has worked. I hope he, himself, will give credit to the members of his staff who have so diligently assisted in bringing this report to you. He also has a letter from Dr. Luck, who was the research analyst we employed to supervise this survey, which letter I hope he will read.

MR. HUGH W. BRENNEMAN: Perhaps one of the most difficult tasks ever assigned to The Council of the Michigan State Medical Society was to select the significant highlights from a study which had millions of factors. In the short space of time which is available to report the results of this study, we can only scratch the surface of the preponderance of information obtained. The report of the Opinion Study of Prepaid Medical Care Coverage in Michigan has some 240 pages. The members of The Council have asked me to direct your close attention to this document when you receive your copy later today.

To help you understand the material in this part of the presentation, several of the graphs and charts from the report have been reproduced and will be projected on the screen.

Before we get into the highlights of the Michigan State Medical Society study, let's take a look at voluntary health insurance plans nation-wide.

[*Slide*] VOLUNTARY HEALTH INSURANCE PLANS (AMA)

1. Nationally, among the voluntary, non-profit health insurance plans, the most widely-accepted plan is the combination service-cash indemnity.

2. Sixty-eight per cent of all voluntary health insurance plans are a combination service-cash indemnity. Michigan Medical Service falls in this category.

3. Thirty per cent of all plans nationally are cash indemnity.

4. Service, or full payment types, accounts for only 3 per cent of the national plans.

5. Blue Shield in Michigan has a larger percentage of the total population of the State enrolled than does any other plan in any other state.

6. There are no Blue Shield plans offered in Michigan other than that offered by Michigan Medical Service. This contrasts with many other states which have one or more Blue Shield plans with one or more corporations administering them.

[*Slide*] ORGANIZATIONAL TYPES OF VOLUNTARY HEALTH INSURANCE

1. This represents the organizational types of voluntary health insurance plans, organized as of December, 1956.

2. There were 58 combination service indemnity plans.

3. There were 28 service plans which were full payment plans.

4. There were 23 cash indemnity plans.

Now, with this background information in mind, let's present the highlights of the Michigan State Medical Society's public opinion study.

[*Slide*] PERCENTAGE OF COVERAGE IN MICHIGAN

1. This shows the percentage of persons in Michigan covered by a prepayment device.

2. Eight out of ten, or 81 per cent of all persons in Michigan are covered by some form of health insurance.

3. Sixty-five per cent of those insured are subscribers to Blue Shield.

[*Slide*] REASONS FOR NOT BEING COVERED

1. Some of the rest of the people said they had no coverage because they "can't afford it"—34 per cent of the answers.

2. "Haven't got around to taking it out" was the second reason, mentioned by 18 per cent.

3. "Don't think we need it" accounted for 15 per cent of the replies.

[*Slide*] WHAT INSURED BELIEVE THEY NOW PAY—ACTUALLY PAY

1. This shows what the insured believe they now pay for premiums—what they actually pay—and what they are willing to pay.

2. Blue Shield subscribers believe they now pay on the average of $5.96 per month for medical-surgical coverage.

3. Blue Shield subscribers actually pay an average monthly rate of $2.83.

4. The total interviewed indicated they were willing to pay an average monthly premium of $6.95 for a policy containing most desired benefits.

5. Blue Shield is used as an example because it was impossible to obtain a rate average from other sources.

[*Slide*] SUBSCRIBER AWARENESS OF CONTRACT BENEFITS

1. The subscriber awareness of contract benefits was appalling.

2. When people were asked what they thought their insurance contracts covered, 95.8 per cent knew they had surgical benefits; 93.9 per cent knew they were covered for obstetrics; 83.6 per cent correctly figured they had diagnostic x-ray; 65 per cent thought medical visits in the hospital were included; but only 44.4 per cent (less than half) knew for sure that they had the benefit of emergency first-aid in the doctor's office. And, more seriously, only 27.8 per cent knew that nineteen surgical procedures, which could be done in the doctor's office, were covered; yet the maximum contract covered all these things.

3. Then they were asked what they thought they had, and here is how they answered: Nearly half—45 per cent—assumed they had diagnostic benefits other than x-ray; 42 per cent assumed that the surgical assistant was paid by the insurance company; 36 per cent figured they were covered when their doctor had a medical consultation with another doctor about their case; 34 per cent banked on the insurance to cover pre- and post-natal care in the doctor's office; and, finally, 32 per cent figured that outpatient diagnostic x-rays were covered. But none of these benefits are covered by existing Blue Shield contracts.

4. Doctors felt that Blue Shield coverage was not sufficiently understood by either the general public or the subscribers. In addition, they felt that only 34 per cent of the medical profession understood the coverage.

[*Slide*] DESIRED BENEFITS—3 PLANS

1. When we asked about desired benefits in the single plan, self and spouse plan, and family plan, we found they ran pretty much alike.

2. Every body in all three plans wanted three in-hospital benefits in particular. Surgical led the list. Diagnostic x-rays was second, and medical visits third. When they were asked to choose what service members of all three plans wanted in a doctor's office, again they were unanimous in their leading choice. Each desired emergency first-aid. The second selection was minor surgical treatment.

3. Relatively fewer people were interested in having medical services in their homes. Less than half of them wanted home calls covered. About the same number wanted ambulance service too.

[*Slide*] TYPE OF COVERAGE DESIRED (MAJOR AND MINOR COSTS)

1. Next we considered the type of coverage desired as it related to major cost items and minor cost items.

2. About 68 per cent wanted both major and minor costs covered.

3. Thirty-two per cent were interested in having major cost items only in their coverage.

[*Slide*] DEDUCTIBLE PLANS

1. Is a deductible plan favored? If so, how much should be deductible?

2. Forty-seven per cent—nearly half of the people—said they favored a deductible plan.

3. About 44 per cent of the union members wanted it.

4. A majority of the over $5,000 income group wanted it—51 per cent.

5. Of the doctors, 82 per cent favored it.

6. On a related question about the liberalization of contracts, 72 per cent of the doctors felt that Blue Shield should develop a minimum coverage contract and then provide "policy riders" at additional cost for additional protective services.

7. Now, how much should be deductible? The first $25 was the choice of nearly half the people.

8. One-third wanted a $50 deductible policy.

[*Slide*] ATTITUDES TOWARD BLUE SHIELD

1. The attitude of people toward Blue Shield was another thing we tried to discover in the study.

2. Public attitude was good. A majority liked Blue Shield.

3. Blue Shield subscribers also had a favorable attitude by a big majority.

4. In the doctors' opinion, they thought the public generally was not entirely satisfied with Blue Shield.

5. Doctors also believed that Blue Shield subscribers were satisfied with the job Michigan Medical Service was doing; in fact, twice as many doctors felt that way.

6. Blue Shield subscribers' attitude toward the cost of the program was uniformly good. There was no significant difference between union members and non-union members and people with incomes over and under $5,000.

[*Slide*] DOCTORS' ATTITUDE

1. The doctors' attitude was measured to see if they thought Blue Shield is providing a satisfactory service.
2. "Yes" was the answer given by 30 per cent.
3. "Yes, but it could be improved" was the response of 50 per cent.
4. Then they were asked whether supervisory controls are necessary.
5. For Blue Shield the answer was "Yes" by a 79 per cent majority.
6. For Blue Cross the answer was "Yes" by an 85 per cent majority.
7. Doctors felt they should establish policing committees on the community level under county medical societies.

The Council has instructed me to read a letter to you which was written by Dr. David Luck, the consultant on this survey, who kept himself in a consultant capacity at all times, and who had questions having to do with methodology, what we should do, how it should be done, and so on, and analyzing everything that was done. His letter reads as follows:

Dear Mr. Brenneman:

"After studying the completed report on the prepaid medical care and coverage surveys, I am glad to accept your invitation to give you my own appraisal of the report.

"In general, I strongly approve of the care taken to report the complete facts and to express the conclusions fully. Although only a highly interested person would read most of this report, in a matter of controversy you properly include practically every breakdown of the data to permit anyone to weigh them and reach his own conclusions.

"The mailed questionnaire was a relatively simple one, in my experience with surveys, which dates back to 1908. The attendant publicity, which I know many people read since so many of my friends mentioned it, together with the easy-to-answer form, would bring in perhaps 20 per cent or higher return when the recipients are highly motivated, in my experience.

"We know from the personal interviewers' reception that people were cordial and had no inhibitions in discussing medical insurance. Therefore, I believe that while methods of medical insurance may be controversial, people are not worried about its costs or often irritated about it, since the Health Council got under 12 per cent return.

"It is interesting also that additional benefits at higher premiums were desired by so many, despite their very exaggerated recollection of the premium rates they pay. To me, this indicates that costs of medical insurance tend to be taken for granted, and are not a source of much public concern.

"Your statements of conclusions and highlights have been stated with care, and genuinely reflect the detailed data. One minor exception is found in statement No. 9 on page 19, 'Half of the people said they paid less than $50,' and so on. This is half of those who had to pay the additional amounts, who constitute 61 per cent of the 75 per cent who called on their insurance plan for benefits.

"Ignoring the 19 per cent who have no health insurance, then, of those who do have insurance I would have said that 22 per cent said they have paid less than $50. That is one misstatement that is made in the entire brochure that I could find in a very thorough and exhaustive review.

"Such corrections as these appear to be very minor, and I believe the report will be judged very sound by the Medical Society members and others who will be concerned with this vital social issue. As it might be useful, I would be glad to offer suggestions on any further edition of the report for a more popular or specialized audience.

"As a layman, and apart from my professional concern with the methodology of this study, I am gratified by the earnestness of the medical profession in meeting the social needs for financial protection in health matters, and I am impressed with the desire to learn and to report exactly what the public thinks, with no idea whatever of inducing bias into their responses."

G. W. SLAGLE, M.D.: Mr. Speaker, what I am going to present is the third part of this survey study presentation. I shall summarize some of the things that have been said and shown on the slides.

The people of Michigan have spoken, and their thoughts, opinions and ideas on medical and surgical care have been accurately recorded and reported. The facts are at hand. Now it is our duty as doctors to scrutinize them carefully and to draw some valid conclusions which will be useful to present any future medical contracts—both those of Blue Shield and all insurance companies that offer policies containing medical and surgical benefits.

In our audience today, there are many representatives from other state medical societies, Blue Shield plans, insurance companies and advisory health agencies. To these people I extend a sincere and warm welcome. In addition, I wish to assure them that all the information we have gathered in this report is available to them right now.

I would like to assure them that the information we have on the Opinion Study of Prepaid Medical Care Coverage in Michigan is valid. You have heard something of how the study was conducted. Throughout the entire period every effort was made to avoid a bias in the opinions. The study was done under accepted standards of survey methodology. At no time was there ever a suggestion made to fit the material and information into a preconceived notion of what the people want in the way of medical services—and what they are willing to budget for those services.

There also are representatives of communication media in our audience today for this presentation. I extend to them the same warm welcome, and assure them that every piece of information in the study is at their disposal. In addition, our Press Room in Parlor A is manned by competent staff personnel who have been intimately concerned with the study. They will be available to answer your questions and help you find the facts you might need to bring this important story to the people of Michigan and the nation.

It is a story of facts which may have tremendous effect upon the lives and welfare of people everywhere. It is a story that we feel they will be interested in because of the unusually great interest the people had while the surveys were being made. This interest was reflected in the high rate of returns.

The facts of the Opinion Study of Prepaid Medical Care Coverage in Michigan have been presented to you by the survey director, Mr. Hugh W. Brenneman. Now let's take a few minutes to see what these facts mean to the public, the insurance companies, the voluntary prepayment programs and the medical profession. Let us take these facts and draw our basic conclusions.

These conclusions, or interpretations, fall into five broad areas. They are:

1. Public awareness of benefits and costs.
2. What people want or think they have as medical coverage.
3. What these same people are willing to budget for this coverage.
4. Deductible type policies.
5. Opinions and desires of the medical profession.

We will take them up one at a time.

First, Public awareness of benefits and costs. We can draw this conclusion from the information contained in the study:

Insurance companies and voluntary prepayment plans which offer medical service coverage need to establish better lines of communication between the company and subscriber. They must explain what benefits are available in policies or contracts and what these benefits cost, because the public generally does not know.

The study disclosed that the public does not fully understand medical-surgical benefit provisions of policies or contracts. The extent of this lack of knowledge as pointed out in this study seems appalling. To me, at least, it is amazing that Blue Shield enjoys such overwhelming popularity with the public in light of these misunderstandings.

While 81 per cent of the people of Michigan have some sort of coverage—and while 69 per cent of these people have used their contracts at some time or other, as a rule they do not know about the benefits in their policies unless they have used that specific benefit. What is more, a patient who believes his contract covers a certain thing and who finds that it does not cannot be expected to continue as an ardent supporter of Blue Shield or any other company.

Added to what is already confusion, we find that subscribers and policyholders have an exaggerated idea of how much they pay for their medical-surgical coverage. The average estimate of monthly premiums for all policies surveyed is $4.12 per month more than the average premium for Blue Shield contracts.

Another stumbling block to our communication with persons insured is the fact that medical science today has produced new specialties. Some of the services from these specialties are included in benefit provisions; yet the specialty itself and what it means to the patient is not fully understood by the public.

We can conclude from our study that people want to add those benefits which they can see or hear—such as ambulance service—and which has a function they readily understand.

This over-all question on the lack of public awareness of benefits and costs is a serious one. The available facts warrant more study to determine what steps can be taken to illuminate and communicate this vital message.

Now, what about the second conclusion pertaining to what people want as medical coverage? We might state it this way:

People are generally satisfied with the coverage they have. However, they want more coverage but are not unanimous in the choice of benefits to be added.

From the facts disclosed today, we can see something of what is in the public mind about the direction in which they are looking for expanded benefits.

One thing is sure: They want what they have, along with some additional items too. There is little difference between the percentage of desire for any single benefit in the family, self and spouse, and single contracts—with the exception of maternity benefits of course.

On the other hand, public opinion is pretty well divided on whether or not to include items which are not covered at present. There is no overwhelming clamor for any particular service, although the highest ranking preference was for diagnostic services (other than x-ray) in the hospital.

Simply because there is no unanimity of opinion on this matter of added benefits does not mean that the policyholders and subscribers are entirely satisfied that their coverage should remain the same as it is today. To the contrary, the diversity of opinion means that there is a relative percentage—small though it may be—of the insured who desire almost every conceivable benefit. A policy containing one or more of these features will find acceptance with thousands of people.

We can sum it up like this: The question of what people want is the crux of this entire study. The answers are in the report which will be distributed after the meeting, but you as delegates must give careful thought to the total findings. This study gives you an accurate and scientific background to aid you in your deliberations.

With an idea of what the people want in mind, let's move along to the next conclusion—what are they willing to budget for medical coverage? Our conclusion might follow along these lines:

People will pay a reasonable increase in premium rates for the added benefits they prefer the most.

In this study the people expressed a willingness to pay an increased premium for a policy which was ideally suited to their needs. Then the study went even further and found that, on the average, the insured were willing to pay $6.95 a month for hypothetical policies they designed themselves. This one fact was conclusive evidence that people will pay for something they want, even though the $6.95 represents an increased rate.

Remember this: There is a great deal of difference in being willing to pay for something, and actually handing over the cash. It does serve to indicate, however, that they are willing at least to pay an increased rate for the coverage they desire the most.

When speaking of monthly premiums, this leads us to our fourth conclusion:

A large number of people favor a deductible type policy in order to reduce monthly premium costs.

Long experience with automobile deductible insurance makes this a familiar term, and there seems to be no confusion in the public mind about the operation of a deductible feature.

There is no overwhelming cry from the public for the introduction of this type of policy—yet 47 per cent of the people (nearly half) favor the idea. The most preferred amount was a $25 deductible.

So, it would seem that if a deductible type contract were introduced there would be definite public acceptance.

Up to this point we have been reporting what the people of our State feel about medical and surgical care programs. As has been pointed out before, the people and the doctors are partners in these programs. Now let's see what the medical profession thinks.

The conclusions which follow are based on the answers that members of the Michigan State Medical Society gave to a doctor opinion survey. From this survey we are able to draw this basic conclusion:

Doctors indicate that Blue Shield might well change its income limits on contracts with an accompanying revision in fee schedules, and that utilization committees be formed on the county medical society level to oversee Blue Shield utilization.

Relatively few doctors believed that Blue Shield's medical service principal should be limited to people with incomes under $5,000. In fact, they recommended that the three income limits be adopted to include a $7,500. Along with the new service limit, however, the doctors felt that a revision of the fee schedule should be forthcoming.

A majority of the doctors feel that Blue Shield's schedule should be raised on a selective basis. Many believed that both premiums and fee schedules should be adjusted as living costs vary.

More than three out of four of the doctors feel that separate contracts should be offered by Blue Shield in addition to current full pay policies, to permit the subscriber to purchase a deductible policy or a co-insurance policy.

Significantly, the doctors felt that Blue Shield and the public will benefit if utilization committees are formed to oversee the utilization of medical care under Blue Shield. The most favored method for this was through the county medical society.

I have drawn together the most predominant categories in the doctor opinion survey. There are many other items that may be of interest to each one of you and your particular specialties, but rather than take your time I would refer you again to the report itself.

This presentation has covered five broad areas in which we have made the conclusions of the study. It has been an analysis of the facts as brought out in our opinion study on prepaid medical care coverage in Michigan.

We do not make an attempt to prove a point; we merely reported the raw figures as they appeared in the study. Let me assure you that no attempt was made to juggle the figures to follow a preconceived idea on medical insurance protection.

As we begin our deliberations about this gigantic, comprehensive study, let us pause for a moment and consider some broad principles which we follow in the

medical profession, some of which are reaffirmed in this study. None is denied in the study.

Our basic job is to give the best medical service available to the people. We must make sure that our patients continue to enjoy the doctor-patient relationship, which can operate to its fullest content only if there is freedom of choice of physician. No third party can interpose in this relationship. We have a responsibility to see that this never happens.

We also have other responsibilities to the people in the development of medical care programs and health insurance coverage. These programs should never straight jacket the people into a rigid pattern of rules and regulations. They must have the broadest opportunity for freedom of choice in all factors.

In addition, it is not our business to tell the public how they should pay for medical services, but it is our duty to help them obtain the broadest possible coverage which fits their needs and fits their willingness to set aside sufficient amounts for these services.

There are going to be changes in medical insurance protection—we know that; yet in making these changes, let us remember to offer adequate option for the varied needs of the people. In the past we have only been able to guess at what these needs and desires are. Now, with the survey completed, we know.

The study is at hand. I urge you to weigh each of the factors closely, in the light of the broad principles which I have just outlined. We have the opportunity to meet our responsibility to the people in developing the best medical insurance program possible. Let's make the best of it. [*Applause*]

* * *

THE SPEAKER: This three phase report was referred to the Reference Committee on Medical Service and Prepayment Insurance.

VI. REPORTS OF THE COUNCIL

By D. Bruce Wiley, M.D., Chairman

May I present a portion of the supplemental report of The Council at this time which pertains to the study that has just been presented.

Committee on Michigan Medical Service

This Committee has held numerous meetings during the past year. It has carefully reviewed all the provisions in the present Michigan Medical Service contracts and those of many other prepayment plans. It has also considered the various suggestions made by members of the Society.

The Committee feels that certain changes in the contracts should be made at this time to better serve the public, to meet more adequately the desires of the subscribers and physicians, and at the same time preserve the basic idea inherent in the Blue Shield Service philosophy.

It must be borne in mind that any proposal must be realistic and actuarially and administratively sound. The attached proposal is presented to The Council for its consideration and subsequent submission to the House of Delegates:

MSMS PREPAYMENT PRINCIPLES

A. General Consideration.—The Michigan State Medical Society has made an intensive study of the development and the operation of the many means currently employed both in Michigan and elsewhere to insure against or to prepay the costs of medical care. The conclusions resulting from that study are set forth below and are based upon the following fundamental considerations:

1. The people of Michigan are entitled to and should have health care which meets the highest standards attainable.

2. Means should be generally available in Michigan which will permit the financing of the costs of necessary medical services and supplies to the greatest extent possible and practical through prepayment.

3. To whatever extent the cost of a particular medical service is not covered by prepayment, such uncovered amount shall be predictable, be known to the patient in advance, and be within his ability to budget for out of income.

The foregoing can be accomplished only if those responsible for rendering the necessary medical services, namely, the physicians of Michigan, assume the further responsibility of establishing within the profession a structure around which sound insurance or prepayment plans can be built, and also a system by which the profession can assure itself, the prepayment plan subscribers, and the underwriters that the structure is functioning in accordance with its commitments.

B. Commitments by the Michigan State Medical Society.—In light of the foregoing, the Michigan State Medical Society undertakes the following commitments:

1. Any contract offered by an insurance carrier or prepayment plan organization which embodies the principles set forth in Section C herein shall receive the endorsement of the Society. This endorsement shall remain in effect as long as the carrier continues to make the contract available.

2. It being the objective of the medical profession to make certain that voluntary health protection be available to all self-sustaining people at reasonable cost, the endorsement of the Michigan State Medical Society will be given only if rates charged by the insurance or prepayment carrier are fair and equitable.

3. The Society will use its best efforts to secure the participation of its members in all contracts endorsed by the Society.

4. A subscriber rendered care by a participating physician will receive "service benefits" as provided in his contract. The basis is set forth in Section D below.

5. The Council of the Michigan State Medical Society will appoint a Medical Care Insurance Committee having the following functions:

(a) To examine all contracts submitted for endorsement. A report will be sent to The Council which will have the authority to issue a certificate of endorsement on behalf of the Society.

(b) To co-operate with the Permanent Advisory Committee on Fees of the House of Delegates concerning the Relative Value Scale and applicable unit values.

(c) To develop review procedures for any matters concerning the subscriber, the physician, the insurance carrier, and others.

(d) To develop Review Committees in each of the Councilor Districts of the Society, nominated locally, which shall be appointed by The Council of the Michigan State Medical Society. These shall function under the direction of the Medical Care Insurance Committee, which will also serve as a unit to which appeal can be made from decisions of the Review Committee(s).

(e) To make such interpretations of the language herein as may be required in connection with the endorsement of contracts.

6. Amendments to or interpretations of the principles set forth herein may be made by The Council of the Michigan State Medical Society during the interim between meetings of the House of Delegates of the Michigan State Medical Society.

7. The Michigan State Medical Society, sponsor of Michigan Medical Service, will urge Michigan Medical Service to make available to any qualified group or individual protection in accordance with the principles herein set forth at fair and equitable rates and pledges its support in such an endeavor.

C. Principles to be Embodied in Insurance Contracts.—

1. There must be complete freedom of choice of

physician by the patient. Nothing in any contract will imply any restriction of this principle.

2. All benefits will be on a service basis consistent with the principles set forth in Section D.

3. The following services must be included in any basic program:

(a) Surgical procedures wherever performed.

(b) Medical services when the patient is confined to a hospital.

(c) Consultation service for surgical cases, obstetrical cases and in-hospital medical cases; surgical assistants where required.

(d) Obstetrical services for the actual procedure in normal delivery, Cesarean section or abortion and complications of pregnancy, but not to include routine prenatal and postnatal care. Optional supplemental insurance by the carrier to cover all obstetrical costs may be offered as provided in No. 4 below.

(e) Anesthesia by a physician not an employe of a hospital.

(f) Diagnostic laboratory procedures shall be provided in the outpatient department of a hospital, a private laboratory, in the physician's office.

(g) Diagnostic and therapeutic radiologic procedures, and therapy shall be provided in the hospital, the outpatient department, or in the physician's office.

4. At the option of the carrier, additional coverage may be provided for other medical services and supplies, such as:

A Home and office calls.

B Benefits for prescriptions filled by a registered pharmacist.

C The furnishing of prosthetic devices.

D Physiotherapy in the outpatient department or the physician's office.

E Other services which may be required in the treatment of the patient.

5. (a) For any necessary service other than surgical and obstetrical and anesthesia, the subscriber shall have, at the time of utilization, a degree of financial participation in and responsibility for medical fees in addition to his premium. This shall be determined by the carrier, but the responsibility of the patient shall be not less than 10 per cent or $5, whichever is more, but not in excess of the scheduled fee allowance. In accordance with the terms of the contract, this amount shall become the obligation of the patient to the physician at the time of service and will be subtracted by the carrier from the payment for service it shall make to the physician. These provisions shall not be applicable to subscribers covered by Plan E. For any calendar year, however, patient participation shall not exceed the following:

Contract for Which Eligible	*Limit of Patient Participation Per Year*
A	$ 25
B	50
C	75
D	100
E	Not applicable

(b) While the provisions of "A" above are strongly urged by the Michigan State Medical Society, any carrier may have the option to waive the provision of "A" by a rider to provide for coverage without subscriber contribution.

6. There shall be five contracts to be known as Plans A, B, C, D and E. Each of these contracts shall apply to a specific income level and, except for *Plan E*, will provide service benefits. The income level shall be determined by a projection of the current rate of earnings of the basic wage-earner in the family and not by family income.

Plan A will provide full service benefits to all subscribers whose basic income is less than $2,500. ***Plan B*** will provide full service benefits for those subscribers whose basic income is $2,500 but less than $5,000. ***Plan C*** will provide service benefits for those subscribers whose basic income is $5,000 but less than $7,500. ***Plan D*** will provide service benefits for those subscribers whose basic income is $7,500 but less than $10,000. ***Plan E***—The fee will be the result of agreement between the patient and his physician. The Plan will pay the applicable "Dollar Allowance" as indemnity to the doctor. This does not preclude the carrier from offering a contract which will insure fees incurred by subscribers in this class.

7. The insurance carrier shall be responsible for classification of subscribers and appropriate designation of the Plan in which they are enrolled. Income designation shall reflect the subscriber's current rate of pay projected on an annual basis. This designation shall be reviewed annually and changed as indicated by the review.

D. Basis of Service Benefits.—1. The Michigan State Medical Society will develop a "Relative Value Scale" which will assign to the individual surgical, obstetrical and other medical services a value in units proportional to the relative value of that service. The Society will determine the applicable value of one unit for each class of benefit. By multiplying the number of units assigned to a procedure by the value of one unit, the "Dollar Allowance" for that procedure is obtained.

2. (A) The Michigan State Medical Society will establish unit values for medical, surgical and obstetrical procedures and anesthesia for each of the Plans.

(B) For diagnostic laboratory procedures and for all radiologic procedures, the unit value will be the same for all Plans.

(C) For any optional benefits offered by a carrier, the Society will establish appropriate unit values.

3. Until the Society establishes a "Relative Value Scale" for Michigan, the scale developed by the California Medical Association shall be used.

4. No participating physician may charge more for a particular service rendered a subscriber than the "Dollar Allowance" payable for that service under the subscriber's contract. Subscribers covered by Plan E, however, shall be responsible for any part of fees to which they agree in excess of the applicable "Dollar Allowance."

* * *

This portion of the report was referred to the Reference Committee on Medical Service and Prepayment Insurance.

The annual report of The Council is printed in the Handbook for Delegates, beginning on page 51.

The Council wishes to present the following supplemental report as of September 22, 1957:

1. *Membership.*—On September 1, 1957, the membership of the Michigan State Medical Society totaled 6,400. This compares very favorably with the total of 6,157 at the same time last year.

2. *Finances.*—

FINANCIAL REPORT FOR PERIOD ENDING AUGUST 31, 1957

ACCOUNT	On Hand 1/1/57	Income to 9/1/57	Expenses to 9/1/57	Balance on Hand 9/1/57
General Fund	$ 89,870.56	$162,765.70	$109,771.05	$142,865.21
Annual Session	.....	31,774.66	8,601.69	23,172.97
Michigan Clinical Institute	.....	13,650.00	13,893.52	— 243.52
The Journal	.....	76,518.52	64,070.20	12,448.32
Public Education	73,891.87	34,049.47	37,861.71	70,097.63
Public Service	3,675.16	19,020.75	17,169.09	5,526.82
Professional Relations	4,897.50	28,531.12	25,328.49	8,100.13
Public Education Reserve	57,245.00	16,303.50	.....	73,548.50
Rheumatic Fever Control	7,675.56	11,774.51	7,491.11	11,958.96
Surplus from Dues	53,614.34	.....	.....	53,614.34
Building Fund	14,124.94	11,130.83	5,073.21	20,182.56
MSMS Headquarters Fund	.....	27,172.50	.....	27,172.50
Totals	$304,994.93	$432,691.56	$289,260.07	$448,426.42

3. *Michigan Medical Service.*—An up-to-date report on this corporation, including the finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow, September 24, at 2 p.m. in this Ballroom of the Pantlind Hotel. All MSMS delegates are members of Michigan Medical Service Corporation and are expected to attend this important annual meeting (which will be preceded by a 12:30 p.m. reception and a 1 p.m. luncheon, with the compliments of Michigan Medical Service, in the Kent State Room of this hotel. (See page 13 of Handbook for report on Michigan Medical Service.)

4. *Michigan's Foremost Family Physician of 1957.*—Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is the privilege of the MSMS House of Delegates. According to established procedure, the field of nominees has been narrowed by The Council to three, from which the House of Delegates elects one. The three nominees are: Daniel J. O'Brien, M.D., Lapeer; John W. Rigterink, M.D., Grand Rapids; Paul Van Riper, M.D., Champion.

5. *MSMS Health and Accident Insurance Program.*—The report to September 1, 1957, supplied by the carrier (Provident Life and Accident Insurance Company of Chattanooga, Tennessee) is as follows:

(1) That over the past two years, on a basis of annual renewals, the average claims from doctors where payment has been made equalled 14.12 per cent, very close to one out of seven.

(2) During this same period 39.7 per cent claim payments were paid per month, or an average of 1.85 payments per working day.

(3) That during this period four accidental death claims have been paid.

(4) As of August 15, 1957, there were forty-one claims in process. Out of these, thirty-two have received payments from the Company, and on these thirty-two, 179 different payments have been made which indicate long-term disability since the Company pays monthly income amounts to these policyholders. The average payment has been $346.28 and the average total amount paid to date to each of these thirty-two claims is $1,937, which again indicates a long-term disability of those who are on the claim rolls at the present time.

6. *Invitations to all New Licensees.*—As instituted in 1956, all doctors of medicine who were licensed to practice in Michigan since the last MSMS Annual Session recently were sent special invitations to attend our 1957 convention. In this group of almost 1,000 physicians, nonmembers as well as members were included with the thought that the Annual Session would indicate to nonmembers some of the many values of association with MSMS, recognized as one of the top three progressive state medical societies in the United States.

7. *Beaumont Memorial.*—The Council is pleased to announce that an agreement between the Michigan State Medical Society and the Mackinac Island State Park Commission, placing ownership of the Beaumont Memorial furnishings (personal property) in the name of the Michigan State Medical Society, was executed on July 13, 1957.

This meeting of minds bodes well for the future of the Memorial. It begins a joint endeavor of the three interested groups—the Michigan State Medical Society, the Mackinac Island State Park Commission, and the Michigan Historical Commission—to make the Beaumont shrine the most interesting and authentic historical museum on Mackinac Island.

Beaumont Memorial Foundation.—Following the approval of last year's House of Delegates, The Council requested the Beaumont Memorial Committee and Legal Counsel Lester P. Dodd to proceed with the incorporation of the Beaumont Memorial Foundation, a nonprofit corporation in the State of Michigan. This has been substantially accomplished, and soon every MSMS member will be formally invited to participate in the Foundation, created to further the purposes and continuing needs of the Beaumont Memorial. Thus, every Michigan physician will know that he is not only eligible to join the Beaumont Memorial Foundation at an annual membership fee, but that it is his privilege to continue the upkeep of this historical gem which belongs to all members of the medical profession and should be the financial responsibility of all.

Our congratulations are extended to Alfred H. Whittaker, M.D., of Detroit, who recently was appointed as a member of the Mackinac Island State Park Commission by Governor Williams—the first M.D. to be placed on this important Commission.

8. *Group Life Insurance for MSMS members.*—During the past year individual members expressed interest in the MSMS sponsoring a program of group life insurance, to round out our group health and accident program. In July, 1957, The Council authorized a survey of the entire membership to ascertain if this service was generally desired. The results of the survey (as of September 16, 1957) are as follows: 2,861 (45 per cent) of the members voted in the survey; 1,828 (64 per cent) of those voting expressed a favorable opinion; 1,033 (36 per cent) voted "No."

The actuary who conducted the survey for MSMS made a comprehensive study of various plans and believes the following program—considering legal requirements and actuarial statistics of MSMS membership—would provide the maximum benefits for the largest number of members:

Classification	*Benefits*
All eligible members through age 49	$10,000 (maixum allowed by Michigan law)
Ages 50 through 64	Reduction from $10,000 of $500 per year up to age 65
Ages 65 through 70	$2,000

The actuary expects that the cost per member will range between $65 and $100 per year depending upon age of insured members. An average premium may be used to apply for all members, but the actuary feels it may be desirable to apply a reduced premium at the younger ages (under forty, perhaps) to attract this group of members. The success of the plan will ultimately rest with our ability to maintain a high degree of interest among the younger members. The actuary further advises that any dividends earned because of favorable experience would be returned to MSMS.

A recommendation on this subject follows.

9. *Opinion Study of Prepaid Medical Care Coverage in Michigan.*—This monumental work, authorized by the House of Delegates in special session on April 27, 1957, is the most significant and largest study of its type ever conducted by a state medical society. A detailed report of the findings has been presented to you today by the Survey Committee (the members being the members of the Executive Committee of The Council) through their spokesmen, Drs. J. J. Lightbody, George W. Slagle and Mr. H. W. Brenneman.

National attention is focused on the results of the study by the medical profession, the public and the insurance companies. Proof of this is in the large number of distinguished guests already on hand for the presentation of the results. Many state and national organizations are represented. They include important personages from insurance companies, health insurance advisory groups, other state medical societies and Blue Shield plans. In addition, editors and writers from the great journals of national and state professional societies are planning reports on the study, as are science writers with established national audiences of readers.

The medical profession of America is waiting for the important decisions that this House of Delegates will make, based on the conclusions of this Opinion Study.

10. *Additional Annual Reports of Committees of The Council.*—Since July the following annual reports of

Council committees have been submitted and are presented herewith for your consideration.

* * *

By common consent the following reports were read by title:

A. *Liaison Committee with Michigan Medical Service.*—There were no matters referred to this Committee requiring its consideration during the past year.

B. *Joint Committee with State Bar of Michigan.*—Your Committee met on several occasions and after detailed discussion as to what should be included in an interprofessional code, and after reviewing sample codes which have been developed in other areas in the United States, it was decided to change the name to an "Interprofessional Statement of Principles," and that the results of the Committee's deliberations be reduced to suitable form by a subcommittee composed of Mr. LeRoy Vandervere and Dr. F. B. McMillan.

This final draft of the "Statement" has been approved by the Committee and by The Council after being edited by the Public Relations Counsel and the Legal Counsel.

The Committee recommended that this "Statement of Principles" be printed and distributed to all members after its final acceptance by The Council of the Michigan State Medical Society and the Commission of the State Bar of Michigan.

C. *Liaison Committee with Michigan State Board of Registration in Medicine.*—Your Committee held one meeting on February 21, 1957, at which E. C. Swanson, M.D., Vassar, Secretary of the Michigan State Board of Registration in Medicine, was present; also, representatives of the Deans of the two medical schools in Michigan. Subjects under discussion were: (a) Screening of abilities of foreign graduates seeking temporary licenses to practice; (b) recommended changes in the administrative rules and regulations of the Board (Section I-B—"Preliminary Education Standards"); (c) National Board examinations; (d) Medical student's entrance procedure.

D. *Special Advisory Committee on WCMS Headquarters Film.*—An attempt is being made to record on film the story of the transition of Wayne County Medical Society headquarters from the David Whitney House to the new Society Building on the campus of Wayne State University Medical School.

The 16 mm sound color motion picture will show the construction process of the new building, along with the background facts of how the project came into being.

The film has been outlined in content and the camera work begun. It will be completed in time for its initial showing at the dedication ceremonies of this new headquarters.

E. *Committee on Uniform Fee Schedule for Governmental Agencies.*—The activities of this Committee have been confined to some correspondence between the members and the Chairman and between the Chairman and the State Secretary and between the Chairman and the Supervisor of Medical Services of the Office of Vocational Rehabilitation.

The intended project of the Committee—a revised fee schedule for governmental agencies—has been held in abeyance because this work is to be implemented by a new standing advisory committee of the State Society.

G. *Healing Arts Study Committee.*—This Committee was charged with a grave responsibility. Stripped of formal verbiage, the task confronting it was to point the way toward a fair solution of the "osteopathic problem."

The Committee accepted its assignment knowing full well that NO solution which it might recommend would be likely to meet with hearty accord and unanimous approval. On the other hand, the Committee recognized the necessity for some constructive action. It did not believe that this type of problem could be solved, to the advantage of the people of Michigan or the medical profession, by pretending it did not exist.

The Committee was equally in accord that it should recommend no course of action which would compromise the high medical standards which presently protect the patients of the medical profession.

With these two boundary lines, the Committee set to work. Conversations were entered into seeking the advice of MSMS members. Informal meetings were held with key representatives of the osteopaths. Public opinion was probed. The Committee deliberated and came to the following conclusions, and, with them, certain recommendations.

The Committee concluded that:

1. The doctors of osteopathy in Michigan are firmly entrenched among the people of Michigan as practitioners of a healing art.

2. That doctors of osteopathy are known and recognized, by the medical profession of Michigan, to be rendering many of the same types of medical service that are doctors of medicine.

3. That several osteopathic hospitals (and so-called "open" hospitals) in this State are deriving their support from public funds and public contributions.

4. That in some localities doctors of osteopathy and doctors of medicine are working in the same hospital without compromising the standards of medical practice in those areas nor jeopardizing the care of the patients.

5. That doctors of osteopathy are not presently as well trained clinically as are doctors of medicine.

6. That remaining in Michigan are many older doctors of osteopathy who continue to follow the cultist practices advocated by the founder of osteopathy.

In view of these conclusions, the Committee sought the opinion of The Council in July, 1957. It has subsequently met and offers the recommendations which follow. The Committee makes no claim that these recommendations, if approved by The Council and the MSMS House of Delegates, will solve the problem. It does believe that these policies, if adopted, can result ultimately in better care for the people and better relationships between these professions without loss to medicine.

Recommendations.—1. That the Michigan State Medical Society approve the medical schools of the University of Michigan and Wayne State University giving courses to osteopaths.

2. That the Michigan State Medical Society delegates to the American Medical Association House of Delegates be instructed to submit a resolution to the AMA House of Delegates at that body's next session, requesting the referral of the problem of MD-DO relationship to the individual constituent state medical societies for action by their individual houses of delegates, and that actions subsequently taken on this question by these houses be considered ethical in relation to the AMA Principles of Ethics.

3. That the Michigan State Medical Society approve consultation between MD's and DO's if and when approved by the American Medical Association.

4. That the Michigan State Medical Society agree to having its Legislative Committee meet annually with the like Committee of the Michigan Association of Osteopathic Physicians to attempt to iron out any legislative problems.

The Committee noted with interest the MSMS policy and relationship to other healing arts professions, that is, chiropodists, optometrists, physical therapists, and so on. It did not choose to comment on these on the basis that the situation seems generally well in hand.

Respectfully submitted

ARCH WALLS, M.D., *Chairman*
B. M. HARRIS, M.D.
F. E. LUDWIG, M.D.
G. W. SLAGLE, M.D.
H. B. ZEMMER, M.D.

H. *Committee on Mediation, Ethics and Grievance.*—Your Committee followed the instructions of the 1956 House of Delegates and sent to all component county medical societies copies of the proposed amendments to Chapter 6 and the suggested additions to Chapter 7 of the Michigan State Medical Society Bylaws.

Two county societies, other than those which approved the draft *in toto*, offered some changes which were duly considered by our Committee.

The revised proposed amendments to the MSMS Bylaws, therefore, are presented to the 1957 House of Delegates for its consideration, which we hope will be favorable:

SUGGESTED ADDITIONS TO BYLAWS RELATIVE TO GRIEVANCE COMPLAINTS FROM THE PUBLIC

Chapter 7 Re Grievances of Nonmembers—Mediation Committees

Note: Re-number subsequent Chapters in Bylaws

Sec. 1—*Policy.*—One of the responsibilities of this Society and of its component county societies is to foster friendly and harmonious relations between the medical profession and the public. To implement such policy, there shall be established within each component county society a standing committee designated as the Mediation Committee. The Councilors of the respective districts of the MSMS within which such a component county society is situated shall be eligible to membership on such committees.

Sec. 2—*Purposes.* The purposes of such Committee shall be:

(a) To afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship.

(b) To resolve misunderstandings between physician and patient or between the component county society and the public.

(c) To reconcile differences between physician and patient by means of persuasion and explanation.

(d) To assist the Ethics Committee of its component county society in maintaining among members high levels of professional deportment.

Sec. 3—*Duties and Powers.*—It shall be the duty and authority of such Committee to:

(a) Receive, hear, examine, investigate and consider complaints from members of the public arising from a physician-patient relationship.

(b) Adopt rules governing the performance of its function; provided such rules are not inconsistent with the applicable provisions of these Bylaws.

(c) Invite response and co-operation from any member of its component county society involved in such complaint. The inexcusable failure of a member to respond to and co-operate with the Committee shall be deemed misconduct, for which discipline may be exacted in the manner provided in chapter 6 of these Bylaws.

(d) Initiate disciplinary measures in the manner provided in Chapter 6 of these Bylaws whenever the Committee has reasonable ground to believe that a member has been guilty of any conduct for which discipline is provided in these Bylaws.

(e) Carry out to the best of its ability the declared purposes of such Committee within the means hereby specified and limited.

Sec. 4—*Limitation of Powers.*—As between the complainant and a member of the component county society, the powers of the Committee shall be limited to efforts promoting understanding or agreement between the parties by means of conciliation. The Committee shall not act as a trial body for the purpose of rendering decisions or awards as a substitute for the judgment of a court or any other similar purpose. The Committee shall have no power to effect discipline or encroach on the function of the Ethics Committee of its component county society.

Amend Chapter 10 of the present Bylaws as follows:

At the end of Section 1, add:

(f) Committee on Mediation

Following Sec. 6, add the following new Section:

Sec. 7. The Committee on Mediation shall be comprised of not more than seven members appointed by the President with the advice of The Council, for terms so fixed that no more than three of them expire during the same year. It shall be the function of the Committee: (a) to receive, hear, examine, investigate and consider written complaints affecting substantial segments of the public arising from the relationship of the medical profession with such segments of the public of this State; (b) to reconcile differences between the profession and the affected segments of the public by means of persuasion and explanation; and (c) to propose and suggest rules of appropriate procedures for use by mediation committees of component county societies.

MISCELLANEOUS CHANGES IN BYLAWS SUGGESTED

Delete from Chapter 2, Sections 6 and 7.

Comment.—The matters provided in these two Sections are in the proposed new Chapter 6 and more appropriately are to be placed there.

Delete from Chapter 2, Section 1 and substitute therefor the following:

Sec. 1. Admission to membership of any component county society is not a matter of right but one of privilege, to be accorded or withheld in the sole discretion of such society. Every component county society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership thereof.

Comment.—The present Section sounds as though the county societies are directed by the MSMS to admit every "reputable practitioner of medicine." Obviously this contradicts or limits the earlier language, which gives the county committee the right to set their own qualifications for membership, and to refuse to admit practitioners who for any reason are not acceptable to a society. Particularly from a legal standpoint, a question may arise should an applicant bring suit against a component county society for refusing to admit him. Such a case is in prospect even now. The applicant may cite to the court the present Section 1, which makes every "reputable practitioner of medicine" eligible to active membership. The proposed new Section may help the situation without doing violence to the principle of local autonomy.

Delete from Chapter 10, Sec. 5, the last sentence.

Comment.—The investigation of ethical misconduct has long been a function of local ethics committee. The State Committee on Ethics has been made essentially an appeal board.

Proposed

Chapter 6—Conduct and Discipline of Members

Sec. 1—*Standards of Conduct.*—It is the duty of every member of this Society and each of its component county societies to conduct himself both professionally and personally in conformity with the high standards imposed on doctors of medicine as a condition of continued membership therein. Such standards include, but are not limited to, the Principles of Medical Ethics which have been and may be from time to time hereafter adopted by the American Medical Association and as interpreted by the Judicial Council thereof.

Comment.—Compare with Constitution, Article III, Section 6. This constitutional provision applies to the society rather than to the individual member. Compare with Bylaws, Chapter 2, Section 6. The proposed Section does not materially alter this present Bylaw provision. However, the standards of conduct are broadened beyond those prescribed in the Principles of

Medical Ethics, and the provision is placed in a more logical position.

Sec. 2—*Grounds for Discipline.* The conduct of a member of this or any of its component county societies which is contrary to the standards prescribed in this Chapter shall be ground for discipline, whether or not the act or omission occurred in the course of a physician-patient relationship. Without limitation of the foregoing, any of the following shall also be ground for discipline:

(a) Unprofessional and dishonest conduct as defined by Act 237 of Michigan Public Acts of 1899, as amended.

(b) Conviction of a felony under the laws of any state or of the United States of America.

(c) Revocation or suspension of license to practice medicine.

(d) Violation or disregard of the constitution, bylaws, principles, rules, regulations or orders of this society or of the member's component county society, or of the American Medical Association.

(e) Defaming or otherwise unjustly reflecting on the integrity, character or professional performance of a fellow member.

(f) Any conduct which is prejudicial to or tends to expose the medical profession or this society or a component county society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals.

Comment.—Present Bylaws specifically name but one ground for discipline—revocation of license to practice medicine. (See Chapter 6, Section 12.) By implication only is violation of the Principles of Medical Ethics made ground for discipline. The present Bylaws do not specifically so state. (See Chapter 2, Section 6.) The proposed section adds several specific grounds for discipline and broadens the general grounds. The Medical Practice Act referred to in subsection (a) above lists the following as constituting "unprofessional and dishonest conduct:"

"(a) The procuring, aiding or abetting in procuring a criminal abortion.

"(b) The obtaining of any fee on the assurance that an incurable disease can be permanently cured.

"(c) The willfully betraying of a professional secret.

"(d) All advertising of medical business in which grossly improbable statements are made, or where specific mention is made in such advertisement of venereal disease or diseases of the genito-urinary organs.

"(e) Having professional connection with, or lending one's name to an illegal practitioner of medicine; or having professional connection with any persons or any firm or corporation who advertises contrary to the provisions of this section, or with any person who has been convicted in a court of competent jurisdiction under the provisions of this section.

"(f) All advertising, of any nature or kind, of any medicine, or of any means for the regulation or reestablishment of the menses.

"(g) All advertising of any matter of an obscene or offensive nature derogatory to good morals or contrary to Sections 34 to 36, inclusive, of Act No. 328 of the Public Acts of 1931, being Sections 750.34 to 750.36 inclusive, of the Compiled Laws of 1948.

"(h) Employing or being employed by any capper, solicitor or drummer for the purpose of securing patients; or subsidizing any hotel or boardinghouse with a like purpose, or paying, or offering to any person, money or any other thing of value with a like purpose, or advertising to do so in any form whatsoever; or the division of fees in a consultation or a reference of a patient to a specialist, when no actual professional service is rendered by the physician referring the case, without the knowledge of the patient or the person concerned in the payment thereof.

"(i) Being guilty of offenses involving moral turpitude, habitual intemperance, or being habitually addicted to the use of morphine, opium, cocaine, or other drugs having a similar effect; or of prescribing or giving away any substance or compound containing alcohol or drug for other than legal and legitimate therapeutic purposes.

"(j) Being guilty of making representations or claims of ability to cure or relieve human ailments by secret methods."

Sec. 3. *Discipline—Definitions and Purpose.* Discipline as used in this chapter shall include reprimand, suspension and expulsion. Any such discipline is not punishment for wrongdoing but is intended solely as a measure necessary to maintain the dignity, integrity, purposes and high principles of this society and of its component county societies.

Comment.—This section is new. It limits discipline to three specific types. The purpose of discipline is emphasized to be nonpunitive. Such explanation may be useful in court should discipline be challenged as being punitive in nature.

Sec 4. *Authority to Discipline.* A component county society may discipline any of its members on any of the grounds and in the manner set forth in this chapter; provided, that every member of this society and of any component county society against whom disciplinary action is proposed or taken shall be accorded the benefit of the procedures in this chapter prescribed, any provisions of the constitution or bylaws of any component county society to the contrary notwithstanding. The expulsion or suspension of any member from a component county society shall be subject, however, to the right of appeal to and review by The Council of the Michigan State Medical Society and the Judicial Council of the American Medical Association as hereinafter provided. Any component county society which has more than 150 active members may by appropriate provisions contained in its constitution or bylaws delegate its authority and power to discipline any of its members to the governing board of such society, in which event all of the functions, duties and powers of a component county society as set forth in this chapter shall be exercised and carried out by such governing boards in like manner and on the same conditions as prescribed for a component county society. Unless otherwise specifically provided by the constitution or bylaws of such component society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component society in the same manner as may be provided for the approval of any other report of such governing board.

Comment.—The first part of this section is a rewrite of present Chapter 6, Section 1. However, it limits appeals to orders of expulsion or suspension. Thus, reprimands would no longer be appealable. Authority is given to the councils of larger societies to expel or suspend. This is not specifically provided in the present bylaws. Under this proposed section, the order to discipline made by a council of a society is not subject to appeal as in the present bylaws (see Chapter 6, Section 10, last sentence). The council action is to be merely subject to approval by the society in the same manner as any report of the council.

Sec. 5. *Ethics Committees.* Every component county society shall have a standing committee designated the Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter. Whenever any matter of alleged misconduct is referred to an Ethics Committee, such Committee shall have the right to conduct investigations and hearings thereon, both informal and formal, and to make findings of fact and recommendations for discipline. It may be assisted by legal counsel for its component county society.

Comment.—This section is new. It requires every county society to have an ethics committee, and pre-

scribes its duties and powers specifically. Also mentioned is the right to have legal counsel to assist or represent the ethics committee.

Sec. 6. *Request for Investigations.* Disciplinary measures shall be initiated by a request of an active member or committee of the society for the investigation of misconduct alleged to have been committed by a member of any component county society. All such requests shall be in writing, signed by one or more active members of the same component county society, filed in duplicate with the component county society, and, as soon as may be, shall be referred to the ethics committee of such society. Each request shall contain a brief statement of the details of each act of alleged misconduct and the approximate time and place thereof. Before any such request and statement shall be considered by any such ethics committee, a copy thereof shall be mailed to the respondent at his last known address by registered or certified mail. It shall be the duty of the respondent, within fifteen days after the receipt of such copy, to make a full and fair disclosure in writing of all material facts and circumstances pertaining to his conduct in relation to the matters set forth in such statement. Such written disclosure shall be mailed to the secretary of the component county society by registered or certified mail. The deliberate failure to make such disclosure or any knowing misrepresentation or concealment of any such facts or circumstances by the respondent shall be ground for discipline.

Sec. 7. *Investigations—Reprimand—Dismissal.* The ethics committee shall make an informal investigation of the matters set forth in any such request and statement. On the conclusion of such investigation, the results thereof shall be informally considered by the committee at a meeting thereof. It shall be the duty of the respondent to attend such meeting on request, and to answer fully and fairly all questions pertaining to his conduct that may be put to him by any member of the committee. If the ethics committee decides that there are no grounds for discipline, the committee may authorize the dismissal of the matter. If, in the judgment of the committee, the material facts disclosed by the investigation are true and are sufficient to warrant only a reprimand, the ethics committee may forthwith administer such reprimand without a formal complaint, unless a formal hearing is demanded by the respondent. It shall be the duty of the ethics committee to report such dismissal or reprimand in writing to the component county society, together with the reasons thereof.

Comment.—Proposed Sections 6 and 7 are new. They provide that disciplinary measures be initiated by a request for investigation, rather than by formal complaint, as is now provided in Chapter 6, Section 3. They lay the foundation for summary discipline in many types of cases, which, under present procedures, are seldom attempted. They provide for informal action in cases of minor violations. Thus, perhaps most matters may be quickly and effectively disposed of without cumbersome and lengthy formal procedures. These sections are intended to exact discipline much more expeditiously and simply in the great majority of cases. Their only counterpart is to be found in present Chapter 6, Section 2.

Sec. 8. *Formal Complaint and Notice of Hearing.* If the ethics committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the ethics committee and subscribed by the chairman or vice chairman thereof. A copy of such complaint shall be filed with the component county society. Thereupon, it shall be the duty of the ethics committee or its chairman to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail not less than thirty days before the date of such hearing. The notice of hearing may be signed on behalf of the committee by its chairman or any member thereof. The giving of such notice shall be conclusive evidence of the finding of reasonable cause to believe that the respondent is guilty of the alleged misconduct.

Comment.—Compare with present Chapter 6, Sections 3 and 4. Please note that under the proposed section the matter has already been screened by the ethics committee. Thus, there will doubtless be many fewer cases to be formally heard. This proposed section also supplies a provision as to who shall fix the time and place of the hearing. There is no provision for this in the present bylaws.

Sec. 9. *Answer and Formal Hearing.* It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with the ethics committee within fifteen days after service of the copy of formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed. It shall be the duty of the respondent to appear before the ethics committee in person at the time and place specified in such notice, and may be represented by counsel. At such formal hearing, it shall be the duty of the respondent to answer fully and fairly all questions pertaining to his conduct which may be put to him by any member of the committee or by counsel for the component county society. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearing.

Comment.—Compare with present Chapter 6, Sections 5 and 7. The proposed section amplifies and clarifies present provisions for answer and hearing.

Sec. 10. *Findings and Report.* If upon formal hearing the ethics committee finds that the charges of misconduct are not established by a preponderance of the evidence, the committee shall dismiss the complaint and shall so report to the component county society. If the committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant discipline by way of a reprimand, the committee shall administer such reprimand, and shall make a written report thereof, together with its findings of fact, to the component county society. If the committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant suspension or expulsion from membership by action of the component county society, the committee shall make a written report of the proceedings had before the committee, and shall include in such report a certified transcript of the evidence, including copies of all documents taken in proof, a summary statement of all previous misconducts for which the respondent has been disciplined, and the committee's findings of fact and recommendations for discipline. Every such report shall be signed by not fewer than a majority of the members of the ethics committee, and shall be filed with the component county society.

Comment.—Compare with present Chapter 6, Section 6. Please note that under new procedure if discipline by reprimand only is found warranted, the report to the society is greatly simplified. No transcript of testimony is required. Under such circumstances, the proposed procedure is less cumbersome and less expensive. In cases where reprimand is recommended, the society as such is called on to do nothing more than to accept the report of the ethics committee. In

the more serious cases, calling for suspension or expulsion, the new procedure follows substantially that now provided. There is a minor change in that if the respondent wishes a copy of the stenographic transcript, he would have to order and pay for his own.

Sec. 11. *Action by Society.* Following the filing of any such report of an ethics committee recommending suspension or expulsion, the component county society shall, at a regular meeting thereof, or at a special meeting called for such purpose, consider and act upon the report and recommendation of the ethics committee. Suspension or expulsion from membership shall require the affirmative vote of not less than two-thirds of members present at any such meeting and entitled to vote thereat, but not including the respondent, who shall have no right to vote on the question. If any measure for discipline is adopted by a component county society, an appropriate order in accordance therewith shall be signed by the president and secretary of such society and a copy thereof served on the respondent and on the Michigan State Medical Society.

Comment.—Compare with present Chapter 6, Sections 8 and 9. The two-thirds vote to suspend or expel remains the same. However, the order of discipline would not require the inclusion of findings of fact, conclusions and reasons as provided by present Section 8. The findings and conclusions of the ethics committee would stand in their place, although the society may reach other findings and conclusions. This should result in considerable simplification.

Sec. 12. *Action on Report—Additional Testimony.* Whenever an ethics committee files a report with its component county society recommending suspension or expulsion as herein provided, the respondent shall be served with a copy of the committee's findings of fact and recommendations so filed, not less than twenty days before the meeting of the component county society at which such recommendations are to be considered and acted on, together with a notice of the time and place of such meeting. The respondent may thereupon file with the society, not less than ten days before such meeting, reasons in writing why the recommendations of the ethics committee should not be adopted. The respondent may also at such meeting appear in person and offer any further reasons why he should not be suspended or expelled from membership; provided, however, that at such meeting no testimony as to any matter of misconduct shall be taken. If it is decided at such meeting that the interests of justice require additional testimony to be taken, the matter shall be re-referred to the ethics committee for such purpose. In such event the ethics committee shall cause such additional testimony to be taken promptly, and shall make a supplemental report thereon, including findings of fact and recommendations based thereon, and shall file the same, together with a certified transcript of such additional testimony with the component county society. A copy of the findings of fact and recommendations contained in the supplemental report shall be served on the respondent as required in the case of an original report, and thereafter the same procedures shall be followed, as in this section, provided in relation to an original report.

Comment.—This is a new provision. It permits a matter to be remanded to the ethics committee for further proof, and avoids a further lengthy hearing before the entire society. This is also a marked simplification.

Sec. 13. *Finality and Effectiveness of Order.* No order of suspension or expulsion from membership shall be final or effective until the respondent shall have been given the opportunity to exhaust his remedy of appeal and review in accordance with the provisions of this chapter.

Comment.—This section is new and intended for the protection of the respondent. It has been pretty well agreed that he should not stand suspended or expelled while he is taking an appeal.

Sec. 14. *Appeal Procedure.* Any member deeming himself aggrieved by an order of suspension or expulsion may appeal to The Council of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for his appeal. The notice shall be served on The Council of the Michigan State Medical Society and on the appellant's component county society by registered or certified mail, addressed to the respective secretaries thereof. Unless notice of appeal is so served within fifteen days following the service on the member of a copy of the order of the suspension or expulsion as hereinabove provided, such member's right of appeal and review shall be conclusively treated as having been waived, and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the component county society shall forward to The Council of the Michigan State Medical Society the complete record of the matter, including copies of the order appealed from, all reports of the ethics committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Council shall thereupon transmit such record, together with notice of appeal, to the Committee on Ethics of the Michigan State Medical Society for consideration, study and report thereon. The Committee on Ethics shall promptly study and review such record on appeal and may request the component county society or the appellant to furnish such further information in writing as the Committee deems necessary for the proper and full review of the matter. Written arguments may be filed with the Committee on Ethics by the component county society and the appellant within thirty days following notice of appeal. Upon conclusion of its study and review of the record, the Committee on Ethics shall make a report in writing to The Council of the Michigan State Medical Society, and shall include in such report all its findings concerning the record and the merits of the appeal, and its recommendations in relation thereto. The Council shall after the filing of such report review the record on appeal, written arguments and recommendations of the Committee on Ethics, and decide by a majority vote to affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the component county society. A copy of such decision shall be promptly served on the appropriate component county society and on the appellant by registered or certified mail. Unless within twenty days after service on them of a copy of such decision the component county society or the appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of The Council of the Michigan State Medical Society shall be final and effective.

Comment.—Compare with present Chapter 6, Section 11. The proposed section follows most of the present procedures. However, it is to be noted that a formal hearing before The Council of the Michigan State Medical Society is no longer required. The Council will treat the report of the Committee on Ethics, with the record before it, in the same manner as the report of any other committee of The Council. The review is intended to be made essentially by the Committee on Ethics. Oral arguments by the appellant before the entire Council will no longer be necessary. It is to be noted that the appeal time has been shortened from sixty to twenty days.

Sec. 15. *Appeal to Judicial Council of American Medical Association.* The appellant, if he was a member in good standing of the American Medical Association at the date of his alleged misconduct, may take

a final appeal from the decision of The Council of the Michigan State Medical Society to the Judicial Council of the American Medical Association.

Comment.—Compare with present Chapter 6, Section 11, last sentence. Important change is that under new procedure there would be no appeal from The Council of the Michigan State Medical Society to the House of Delegates, as now provided in Chapter 6, Section 10. It is also to be noted that unless the appellant is a member of the American Medical Association, he cannot appeal to its Judicial Council.

Sec. 16. *Exception to Procedures.* Any member of a component county society whose license to practice medicine shall have been revoked or suspended, or who shall have been convicted of a felony in any state or federal court, may be summarily expelled from his component county society without benefit of or resort to the procedures prescribed in this chapter. In recognition of the legal right of a person to appeal from such revocations, suspensions or convictions, no such summary expulsion shall be effective until the order revoking or suspending license to practice medicine or the judgment convicting of a felony shall have become final and effective.

Comment.—Compare with present Chapter 6, Section 12. Please note added grounds for summary expulsion and protection afforded the member until the grounds become final and effective.

Sec. 17. *Effect of Suspension or Expulsion.* Whenever a member of any component county society is suspended or expelled from such society, he shall thereby also stand automatically suspended or expelled from the Michigan State Medical Society.

Comment.—Compare with present Chapter 2, Section 7. The present section may be deleted so as not to be redundant with this proposed section.

Sec. 18. *Construction.* Procedures under this chapter of the bylaws shall be as summary as may be reasonable. No investigation or proceeding hereunder shall be held invalid by reason of any non-prejudicial irregularity or for any error not resulting in a miscarriage of justice. The provisions of this chapter shall be liberally construed for the maintenance of the dignity, integrity, purposes and high principles of this society and its component county societies, and shall apply to all pending matters of misconduct as far as may be practicable and to all future matters, notwithstanding the alleged misconduct occurred prior to the adoption of the provisions of this chapter as part of the Bylaws of the Michigan State Medical Society.

Comment.—This section is new and declares a policy against hypertechnicality.

SUMMARY OF MAJOR CHANGES

Eliminations from Present Chapter 6.—

1. Formal complaints and formal hearings for minor infractions.
2. Right to appeal from reprimand.
3. Right to appeal from council of county society to county society.
4. Right to appeal from MSMS Council to House of Delegates.
5. Right of appeal by nonmembers of AMA to Judicial Council of AMA.
6. Necessity for following prescribed procedures when member is convicted of a felony.
7. Certain long notices.

Additions to Present Chapter 6.—

1. Standards of conduct.
2. Specification of grounds for discipline.
3. Investigation procedures.
4. Summary method of disposing of minor infractions.
5. Protection of member while he takes appeal.
6. Increased responsibilities and duties of county ethics committee.
7. Clarification and better specification of procedures.
8. Rules for interpretation of bylaw provisions.

(End of Committee Reports)

12. *Matter referred to The Council by the 1956 MSMS House of Delegates:* Resolution re establishment of Department of General Practice in medical schools (see main Annual Report, page 90): University of Michigan Dean A. C. Furstenberg, M.D., on September 16, sent this supplementary information:

"In view of the fact that this matter is now being considered by a special committee composed of representatives of the American Medical Association, the Association of American Medical Colleges, and other organizations, I think it would be well now to wait until this group has reached their conclusions. No doubt they will have recommendations to make, and I shall bring them to the attention of the Executive Faculty for serious consideration when they are available."

Recommendations

We respectfully invite to your attention the four recommendations in the original Annual Report of The Council, printed in the Handbook on page 95. They read as follows:

1. That The Council be authorized to send MSMS representatives to Washington, D. C., in 1958, on the occasion of the Annual Michigan Day, as recommended by last year's House of Delegates.
2. That serious consideration be given to the recommendations of the Committee on Mediation, Ethics and Grievance.
3. That the Legislative Committee's resolution re registration of doctors of medicine be approved.
4. That The Council recommends that the Michigan State Medical Society dues for 1958—for one year only—be increased $50 to raise sufficient funds to start the MSMS building as soon as possible.

The Council respectfully submits two additional recommendations:

5. That The Council be authorized to pursue its study of group life insurance to the end that MSMS can offer as an added benefit of membership the best program tailored to the needs of Michigan's medical men.
6. That The Council be authorized to arrange councilor conferences prior to the Annual Session, to continue communication with and impart information to the membership.

Respectfully submitted,
D. Bruce Wiley, M.D., *Chairman*
W. B. Harm, M.D., *Vice Chairman*
A. E. Schiller, M.D.
O. B. McGillicuddy, M.D.
H. J. Meier, M.D.
Ralph W. Shook, M.D.
C. Allen Payne, M.D.
H. H. Hiscock, M.D.
H. B. Zemmer, M.D.
L. C. Harvie, M.D.
G. B. Saltonstall, M.D.
W. S. Stinson, M.D.
W. M. LeFevre, M.D.
B. T. Montgomery, M.D.
T. P. Wickliffe, M.D.
B. M. Harris, M.D.
G. Thomas McKean, M.D.
William Bromme, M.D.
K. H. Johnson, M.D., *Speaker*
J. J. Lightbody, M.D., *Vice Speaker*
Arch Walls, M.D., *President*
G. W. Slagle, M.D., *President-elect*
L. Fernald Foster, M.D., *Secretary*
W. A. Hyland, M.D., *Treasurer*
W. S. Jones, M.D., *Immediate Past President*

* * *

The report concerning Michigan Medical Service was referred to the Reference Committee on Medical Service and Prepayment Insurance.

The Healing Arts Committee report was referred to the Reference Committee on Resolutions.

The report of the Mediation-Ethics-Grievance Committee was referred to the Reference Committee on Constitution and Bylaws.

VII. FIFTY-YEAR AWARDS

THE SPEAKER: We are very happy to welcome these fifty-year members. I know that to each of the rest of us it is a distinct honor to realize that these fine men have been in the profession of medicine for this period of time. [*Applause*]

Fifty-year pins were awarded to the following members:

Burton R. Corbus, M.D., Grand Rapids
Fred J. Drolett, M.D., Lansing
Clarence Gillette, M.D., Niles
C. M. Mercer, M.D., Battle Creek
Gerhardus J. Stuart, M.D., Grand Rapids
S. W. Thieme, M.D., Ravenna
Henry E. Thompson, M.D., Detroit
John VerMeulen, M.D., Grand Rapids
Udo J. Wile, M.D., Ann Arbor
Aaron V. Wenger, M.D., Grand Rapids.

* * *

The meeting was recessed at 1:10 p.m.

MONDAY AFTERNOON SESSION

September 23, 1957

The meeting reconvened at 2:30 p.m., K. H. Johnson, M.D., Speaker of the House of Delegates, presiding.

VIII. REPORT OF DELEGATES TO AMA

By W. A. Hyland, M.D.

It is usual for the Chairman and delegates to the American Medical Association to report on what has transpired since the last meeting of the AMA. The report of the June session of the AMA in New York is printed in the Handbook, pages 103 to 111 inclusive.

Results of the Seattle meeting last December were reported in the February JOURNAL with the proceedings of the December meeting of The Council of the Michigan State Medical Society.

* * *

THE SPEAKER: The report will be referred to the Reference Committee on Officers' Reports.

IX. REPORT OF THE WOMAN'S AUXILIARY

By Mrs. A. C. Stander

The Woman's Auxiliary is very happy to have the opportunity to report to her Society the work accomplished this past year. The theme for our year was "Full-Time Citizenship." This theme was picked not only because it was a Presidential election year but because it should be a daily task for all of us.

Your Auxiliary was happy to be of service at election time with the "Get-Out-The-Vote" campaign. We set up telephone centers in dozens of important spots throughout the State. At this time we again realized the importance of organization. Where we were organized we quickly accomplished the goal you set; but in the unorganized localities we were helpless. Fortunately, the unorganized areas are dwindling as wives of doctors realize they, too, have a part and place in the medical profession.

At present we have forty-six organized county auxiliaries with a membership of 3,023. This constitutes only 50 per cent of the wives of members of the Society.

In county auxiliary programming, Mental Health and Safety took top billing. In Public Relations we did a great deal of studying and talking about science fairs. It seems to be a "natural" for a group such as ours.

This next year the National Science Fair will be held in Flint.

We are also happy to report that over 50 per cent of our auxiliaries are working in one of the phases of civil defense. We have kept our membership informed on all pertinent medical bills. Much work has been done on the Jenkins-Keogh bill. Even though the Treasury admitted the validity of the principles involved, they were reluctant to give up the revenue.

In *Today's Health* we work so hard for such little results. Since all offices of doctors have magazines, and since you can have a subscription to *Today's Health* for the same price of a comic magazine, perhaps you can tell us how we can sell it to you.

In the American Education Foundation we had a grand total this year of $3,946.47, an average of over $1.30 per member. Although this is a small contribution, we at least feel we are helping to maintain the independence of our medical schools from government control.

Our Tuberculosis Speaking Project included eighty-eight schools, with 2,910 students entering. It was the Auxiliary President's pleasure to award the winners with gold keys during a broadcast from Lansing.

One always keeps the very best for the last. Michigan leads the nation with 357 Recruitment Clubs in the high schools, with over 5,000 students as members. These Recruitment Clubs include future nurses, technologists and other allied medical fields. The money contributed to the Recruitment Clubs, loans and outright scholarships, came to a grand total of $10,410. This year with our assistance thirty-two nurses graduated—eight practical, three postgraduate nurses, and five medical students.

The most inspiring and rewarding experience has been for the Auxiliary President to travel over 8,000 miles within this State and view the work of the county auxiliaries. Individual members, too, by participating in almost every type of civic venture, make for good public relations and good community relations. The intangible value of these endeavors is difficult to assess, but its community value is nevertheless important.

Looking over our year's activities, I feel there is perhaps one link in the chain that could be strengthened. We are your Auxiliary—your helpmates in medical work—your wives. However, there is no definite method of liaison or definite instruction from your Society. Your Auxiliary is very busy carrying on in many fields of medical auxiliary work—but is it the most important work to be accomplished in our State? Does it meet with the full approval of the Society?

The Advisory Committee has been very helpful, but appears to be too remote from the active administration of the Society. Science Fair is one example. Since the National will be in our State, we have tried hard to have a plan of work for local auxiliaries to follow if they so wish, but there has never been time to sit down with our Society and talk this over. These Science Fairs may be most important as good public relations in our communities, or perhaps you may feel this is not a project that we should undertake. I do not know the answer. Perhaps a discussion of Auxiliary affairs at an executive meeting of The Council may crystallize what the Society wishes of its Auxiliary.

The Auxiliary wishes to thank the fine staff in Lansing; Mr. Warren Tryloff, for his great help with our Auxiliary News; our Society, for the financial support of our convention, and Dr. J. E. Hauser, our Advisory Chairman, who has been a real friend to us all year.

Thank you again for giving us the time during your very important meeting to tell you about your Auxiliary's work during the past year.

THE SPEAKER: The report will be referred to the Reference Committee on Officers' Reports.

X. REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS

By Miss Doris Jarrad

During the past year representatives of the Michigan State Medical Assistants' Society attended functions of the Michigan State Medical Society and its ancillary groups.

We were represented in Milwaukee, Wisconsin in October, 1956, at the first annual meeting of the American Association of Medical Assistants. Miss Hallie Cummins, our Immediate Past President, was selected as Michigan's delegate to the National Board of Directors, and served as Chairman of their Executive Committee this first year.

Many Michigan members are serving on and heading committees in the national organization. R. W. Shook, M.D., of Kalamazoo, Vice Chairman of the State Advisory Committee, was among the physicians attending. The advice of the Advisory Board on the many problems concerning the adoption of the first Constitution and By-laws was valuable and very much appreciated. The second annual meeting will be held in San Francisco on October 4-5-6, and Michigan will be represented by five delegates and several alternates.

Two President's Conferences were held this year. These conferences are training programs for officers and standing committee chairmen of component medical assistant societies. The themes of these two conferences were public speaking and an organization workshop with presentation of job manuals for each officer and standing committee chairman. This latter subject will be presented to the national organization in October in an open forum.

A study was made of a method of voting by mail for the annual election of officers, and the necessary changes in the Constitution and Bylaws to accommodate this are being presented to the membership at this annual session for their decision. A study was made by the Budget and Finance Committee with the resulting recommendation that the State dues be increased from the 1949 budget figure of $2 per member to $5. The necessary change in the Constitution and Bylaws to allow this increase is also being presented to the membership for their approval.

In May our Publicity Committee was reorganized, and *The Bulletin*, official publication of the Michigan State Medical Assistants' Society, was printed and mailed to each member for the first time. *The Bulletin* is to be issued quarterly, and it is hoped that with an increase in advertising it will be possible to carry conference and convention addresses so that all members may benefit from this fine material.

A Standing Committee on Education was initiated this year, and after contacting various higher educational units in Michigan the recommendations of this Committee were formulated and presented to the Michigan State Medical Society's Advisory Committee to Medical Assistants and to The Council of the Michigan State Medical Society.

In essence, the recommendations were: The Michigan State Medical Assistants' Society wishes to hold an Educational Seminar annually, coincidental with the Michigan Clinical Institute. This Educational Seminar is to complement the educational session held at the annual meeting of the Michigan State Medical Assistants' Society. Both of these educational sessions will be designed to tie in and be a part of a year-round extension course for medical assistants.

It is the recommendation of the Education Committee that the University of Michigan be requested to establish this extension course, and that some credit or award for attendance at, and completion of, the course be given.

Further, that the Michigan State Medical Society lend its name to this certificate, and that the Michigan State Medical Society request the Michigan Foundation for Medical and Health Education to lend its name to such a certificate, and that these organizations use their facilities to publicize the names of successful participants in the courses.

The Council approved these recommendations, and preliminary plans have been made to hold the first of these Seminars on March 19, 1958, at the Fort Shelby Hotel.

We are indebted to Mr. Jack Pardee and Mr. Hugh Brenneman of the Public Relations Department of the Michigan State Medical Society for their valuable assistance in this program.

We now have close to 1,000 members. Two additional groups have formed in the Upper Peninsula. The Upper Peninsula Medical Assistants' Society held its first annual convention in June. This was held in conjunction with the Upper Peninsula Medical Society's annual meeting.

Branch and Eaton Counties have become component societies this year. Our Membership Committee has contacted the county medical societies and medical assistants in nineteen unorganized counties, and it is hoped that next year these groups will be formed. We wish to thank the county medical societies, Michigan Medical Service representatives, and drug detail men for their enthusiasm and help in making these organizational meetings possible.

The Michigan State Medical Assistants' Society was contacted by the Ontario Medical Association for suggestions and advice on the organization of the Ontario Medical Secretaries' Association. The State Medical Society graciously "hosted" this meeting.

The Michigan State Medical Assistants' Society is grateful to our Advisory Committee and The Council of the Michigan State Medical Society for the confidence and support entrusted to us in our undertakings. We appreciate the honor and privilege afforded by this trust.

We would like to extend an invitation to each of you to attend any or all of our functions being held at the Manger-Rowe Hotel on Wednesday and Thursday of this week.

THE SPEAKER: This report will be referred to the Reference Committee on Officers' Reports.

XI. SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

We now come to the selection of Michigan's Foremost Family Physician for the year 1957. As you know, three names have been submitted and selected by The Council for presentation to you. I will ask the Secretary to read the biographies, following which the vote will be by ballot.

[Secretary Foster read the biographies of the nominees for Michigan's Foremost Family Physician.]

THE SPEAKER: I should like to appoint the following members as tellers: Drs. Russell Fenton, R. A. Rasmussen, A. W. Strom and J. G. Bielawski.

[*Balloting.*]

THE SPEAKER: I am happy to announce that the result of the voting shows that Dr. Van Riper has been selected as Michigan's Foremost Family Physician of the Year. [*Applause*]

XII. RESOLUTIONS AND MOTIONS

XII—1. PROPOSED INCREASE IN DUES FOR BUILDING FUND (THORUP)

D. W. THORUP, M.D. [Berrien]: I have a resolution from the Berrien County Medical Society:

"Whereas, the requested increase in dues of $50 is unusual and proposes the expenditure of a large amount of the Society's funds; therefore, be it

"RESOLVED: That (1) further consideration be

given to designating this sum as an assessment rather than an increase in dues.

"(2) Action in this matter be deferred until such time as the county societies and, through them, the entire membership of the Michigan State Medical Society, be given further definite information as to the necessity of constructing improved headquarters, the staff to be housed, the location, the plan of construction, the cost, the estimate of permanence, funds already available, and any other pertinent information, in order that the membership may be better informed regarding this activity of the State Society and better judge the advisability of such an expenditure at this time.

"(3) Assurance be given that this additional added amount will be for one year only.

"(4) Payment of any such sum, if it be levied, be arranged in divided amounts."

This resolution was referred to the Reference Committee on Reports of The Council.

XII—2. RE PROPOSED INCREASE IN DUES FOR BUILDING FUND (BABCOCK)

W. W. BABCOCK, M.D. [Wayne]:

"Whereas, a true estimated total cost for the new headquarters of the Michigan State Medical Society is not known, and

"Whereas, this cost will determine the method of procurement of monies for the project; therefore, be it

"RESOLVED: That The Council of the Michigan State Medical Society and/or the Committees on Site and Big Look be directed to explore the cost of a suitable real estate; and, furthermore, be it

"RESOLVED: That an architect be employed to draw up plans and specifications and obtain an estimate of the total costs, fees for this to be taken from the Building Fund; and be it further

"RESOLVED: That when total costs are estimated, that methods of payment be presented to the members of the House, and until such times there shall be no further increase in MSMS dues relating to a building fund."

THE SPEAKER: This will be referred to the Reference Committee on Reports of The Council.

XII—3. RE BYLAWS AMENDMENTS AND MEMBERSHIP (Chapter 2, Section 1—Regulation of Membership)

E. H. FENTON, M.D. [Wayne]:

"Whereas, Chapter 2, Section 1 of the MSMS Bylaws states: '. . . each reputable practitioner of medicine who meets the requirements specified in the Bylaws, Chapter V, shall be eligible for active membership,' and

"Whereas, this statement limits the prerogative of the county medical society to set its own qualifications for membership, and

"Whereas, the implication that membership is a right and not a privilege raises legal questions and may encourage legal redress; therefore, be it

"RESOLVED: That Chapter 2, Section 1 of the Bylaws be deleted and the following substituted: 'Section 1. Admission to membership of any component county society is not a matter of right, but one of privilege, to be accorded or withheld in the sole discretion of such society. Every component county society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership thereof'."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

XII—4. RE FREE CHOICE OF PHYSICIAN IN ALL MEDICAL SERVICE PLANS

O. J. JOHNSON, M.D. [Bay-Arenac-Iosco]: This resolution is introduced at the request of the Bay-Arenac-Iosco County Medical Society:

"Whereas, it appears imminent that there will be new types of medical service offered to the public by a new organization in Michigan, and

"Whereas, it is evident in the other states that these situations can be best dealt with by a firm prearranged program including the free choice of physician, and inculcating the ethics and proper relationship of the patient, the medical profession and a third party intervention; now, therefore, be it

"RESOLVED: That The Council of the Michigan State Medical Society proceed with dispatch to draw up the proper guide for relationship with these new organizations, similar to those submitted to the House of Delegates of the AMA in New York in June, which guides were drawn up by the Council on Industrial Health and the Council on Medical Service of the AMA."

THE SPEAKER: This resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XII—5. RE FEDERATED FUND RAISING DRIVES

R. V. WALKER, M.D. [Wayne]: This is a resolution from Wayne County on fund raising drives:

"Whereas, single disease health agencies emphasize the great emotional appeal of certain diseases and tend to distort their true relation to total health, and

"Whereas, doctors of medicine in the final analysis are responsible for the health of the nation, and any voluntary health agency expenditure or health agency fund-raising campaign that is not in conformity with the prevailing policy of their medical society can be detrimental to the total good, and

"Whereas, the Michigan United Fund is well organized to adequately conduct State-wide fund raising drives for health agencies as well as analyze programs and budgetary needs; be it

"RESOLVED: That the Michigan State Medical Society House of Delegates approve in principle federated fund raising for all voluntary health agencies, and the raising of funds for such federation through a single drive at either the local or State-wide level."

THE SPEAKER: This resolution will be referred to the Reference Committee on Miscellaneous Business.

XII—6. RE ESTABLISHMENT OF FULL-TIME CHAIRS IN TWO MEDICAL SCHOOLS ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

R. W. TEED, M.D. [Washtenaw]:

"Whereas, disease prevention is a function of medical practitioners in the locales of their practice, and

"Whereas, the epidemiological approach to preventive medicine is designed primarily for those who expect to engage in private practice, and

"Whereas, all medical students and practicing doctors of medicine should be adequately trained in the prevention of disease and should have full realization of and carry out their responsibilities in public health, not only to their own patients but also to such agencies as are designated by custom and statute with responsibilities for the public health and welfare, and

"Whereas, it is the firm conviction of this Section on Preventive Medicine and Public Health of the Michigan State Medical Society that the curricula as presently organized in the medical schools of the universities of this State will be improved by the addition of courses of training in public health and preventive medicine, organized with full departmental status; now, therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates request that The Council of the Michigan State Medical Society suggest the

establishment of a full-time Chair of Preventive Medicine and Public Health be considered by each of the two medical schools located in the State of Michigan."

Resolved portion of this resolution was amended by reference committee (See page 124)

THE SPEAKER: This resolution will be referred to the Reference Committee on Hygiene and Public Health.

J. R. RODGER, M.D. [Northern Michigan]: I have three resolutions.

XII—7. RE HONORARY MEMBERSHIP FOR W. J. BURNS, LL.B.

"Whereas, Mr. William J. Burns has served the cause of organized medicine for thirty-two years, of which five were with the Wayne County Medical Society and the last twenty-two have been with the Michigan State Medical Society, and

"Whereas, he has maintained an unusually effective liaison with many other allied organizations to the mutual advantage of all concerned, and

"Whereas, he has given of his time and efforts enthusiastically and unselfishly, and has contributed in no small degree to the present high position of leadership of the Michigan State Medical Society; therefore be it

"RESOLVED: That this House of Delegates grant an Honorary membership in the Michigan State Medical Society to Mr. William J. Burns." *[Applause]*

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

XII—8. RE DISTRIBUTION OF INFLUENZA VACCINE

J. R. RODGER, M.D.:

"Whereas, in the current Asiatic flu vaccination program it has been the policy of the United States Post Office Department to notify all postmasters that they may order vaccination material for the employes in their offices directly from the manufacturer without prescription, and

"Whereas, such a policy places upon the manufacturer the responsibility of determining a priority in a period of scarcity rather than by having such a priority determined by the health personnel of each community, and

"Whereas, there are other groups in the Public Health Service's priority list for Asiatic flu vaccinations who are just as essential or more so to the health and other basic community services than are postal employes; therefore, be it

"RESOLVED: That this House of Delegates instruct the Michigan delegation to the American Medical Association to present a resolution pointing out the unfairness to other groups of the Post Office Department procedure; and that such a resolution be sent by the AMA to the U. S. Public Health Service and other appropriate governmental bodies in order to prevent a recurrence of such an unfair procedure in the event of a future similar medical emergency."

THE SPEAKER: This will be referred to the Reference Committee on Hygiene and Public Health.

XII—9. RE REFERRAL TO AMA OF HEALING ARTS PROBLEM

J. R. RODGER, M.D.:

"Whereas, the problems of the relationship of doctors of medicine to doctors of osteopathy cannot adequately be settled on a State level until there has been a solution reached on a national level, and

"Whereas, a state medical society should not adopt a course of action at variance with the Code of Ethics of the American Medical Association; therefore, be it

"RESOLVED: That the Michigan State Medical Society should not at this time adopt a course of action in relation to the problem of osteopathy which is at variance with the current position of the AMA on this matter; and be it furthermore

"RESOLVED: That this House of Delegates instruct the Michigan delegation to the AMA to introduce a resolution calling for a reconsideration of the osteopathic problem, such resolution to be introduced at the discretion of the Michigan delegation, but not later than the June 1960 session of the AMA."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

XII—10. RE MERGER BLUE SHIELD AND BLUE CROSS

R. F. FENTON, M.D. [Wayne]:

"Whereas, the public in general fails to distinguish between Blue Cross and Blue Shield, and

"Whereas, many mutual problems exist involving Blue Cross and Blue Shield, and

"Whereas, both the public and the members of the medical profession are confused as to the various problems of the Blue Cross and the Blue Shield; be it

"RESOLVED: That this House of Delegates go on record as favoring a merger of the Michigan Medical Service and the Michigan Hospital Service."

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XII—11. RE PROPOSED CHANGES IN BYLAWS OF MICHIGAN STATE MEDICAL SOCIETY

(Chap. 6—Discipline of Members)

SIDNEY ADLER, M.D. [Wayne]:

"Whereas, at the 1956 session of the House of Delegates of the Michigan State Medical Society certain changes to Chapter 6 of the Bylaws, entitled 'Conduct and Discipline of Members' were proposed, and

"Whereas, the constituent county societies should be allowed local autonomy in matters dealt with in these proposals, and

"Whereas, rules set down in detail may not apply equally well to all county societies, and

"Whereas, the ends of justice are fully met if procedures in disciplinary actions are fair; therefore, be it

"RESOLVED: That the proposed changes to 'Conduct and Discipline of Members' be not approved except for those sections outlining appeal procedures; and be it further

"RESOLVED: That the following amendments be made to Chapter 6 of the present bylaws of the Michigan State Medical Society:

"Section 1: Add the following words: 'These provisions conform to Article XIII, Section 75 of Robert's Rules of Order': 'A component county society may expel, suspend or otherwise discipline any of its members in accordance with the provisions of its constitution and bylaws; provided, however, these provisions conform to Article XIII, Section 75 of Robert's Rules of Order with the exception of the following restriction: "After charges are preferred against a member, and the assembly has ordered that he be cited to appear for trial, he is theoretically under arrest and is deprived of all rights of membership until his case is disposed of." '

"Section 2. Retain as is: 'Efforts at conciliation and adjustment of differences shall precede formal complaint against a member sought to be disciplined.'

"Sections 3, 4, 5, 6, 7, 8, 9 (these sections outline procedures that county societies must now follow in disciplining members): Delete.

"Sections 10, 11, 12: Substitute Sections 13, 14, 15, 16, 17, 18 from the Proposed Amendments on Conduct and Discipline of Members."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

XII—12. RE THE EXPANSION OF MEDICAL SCHOOL FACILITIES

MILTON A. DARLING, M.D. [Wayne]:

"Whereas, the graduates of the medical schools in Michigan are insufficient in number to meet the needs of our State for increased medical services, and

"Whereas, with our expanding population and economy this shortage will become increasingly acute, and

"Whereas, the period of years (at least five) between any increase in medical school enrollments and the availability of additional physicians makes action now quite imperative, and

"Whereas, the most economical and immediately available means of adding to the number of medical students can be achieved by increasing the funds available to the College of Medicine of Wayne State University in the amount needed to provide the necessary personnel for fifty additional students in the entering class for September, 1958, and

"Whereas, there is no lack of fully qualified applicants for such an expanded enrollment; now, therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society respectfully urges the Governor and the Legislature to give immediate consideration to this problem and the solution as hereinbefore suggested; and be it further

"RESOLVED: That the House of Delegates offer the services of its members in a continuing study of the requirements and the facilities for medical education."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

XII—13. CREATION OF STUDY COMMITTEE RE PRACTICE PRIVILEGES IN PUBLIC HOSPITALS

H. A. FURLONG, M.D. [Oakland]: This resolution is introduced at the request of the Oakland County Medical Society.

"Whereas, the right of public hospitals to formulate rules and regulations for the control of medical practice within the hospital has been challenged by litigation, and

"Whereas, it is in the interest of public health and welfare that hospitals formulate such rules and regulations for the control of medical practice within public hospitals in order to maintain standards of hospital approval for accreditation and postgraduate training; therefore, be it

"RESOLVED: That the Oakland County Medical Society requests the Michigan State Medical Society to appoint a study committee if it is deemed timely and advisable. The duty of the committee would be to prepare an amendment to the Medical Practice Act of Michigan which will establish the right of public hospitals to control medical practice within the hospital."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

XII—14. RE STUDY OF RELATIVE VALUE SCHEDULE OF SERVICE

H. W. HARRIS, M.D. [Ingham]: This resolution is designed to implement in part the recommendations of The Council regarding prepaid medical service.

"Whereas, a "fee for services rendered" is the most usual method of reimbursement to members of the medical profession, and

"Whereas, there are disagreements among various members and groups within the profession as to the equity of various 'fees for services,' and

"Whereas, a third party can never settle this problem to the satisfaction of the members of the profession nor for individuals seeking such services; therefore, be it

"RESOLVED: That the Permanent Advisory Committee on Fees, a Committee of the House of Delegates, be entrusted with the duty of investigating the Relative Value Schedule of Services as developed by the California State Medical Society with a view to a similar program for the Michigan State Medical Society; and be it further

"RESOLVED: That this Committee be authorized to conduct such hearings as are necessary to obtain information, appoint those individuals or groups it deems advisable as agents for securing information and the drafting of such a schedule of relative value of services; and be it further

"RESOLVED: That those expenses necessary for the satisfactory completion of this task, including meetings, secretarial work and the employment of trained analysts, if need be, shall be borne by the Michigan State Medical Society; and be it further

"RESOLVED: That this work proceed at once and that a preliminary report be ready by the time of the January meeting of The Council, at which time The Council shall recommend further disposition."

THE SPEAKER: This will be referred to the Reference Committee on Reports of The Council.

XII—15. RE CREATION OF NATIONAL OR STATE CLEARING COMMITTEE TO INVESTIGATE NEW DRUG CLAIMS

P. S. SLOAN, M.D. [Houghton]:

"Whereas, all practicing doctors of medicine are being bombarded with literature, testimonials, caricatures, claims of new cures, and useless samples, and

"Whereas, the volume of this material is such that nearly all goes unnoticed and discarded, and only further adds to the present confusion relative to new pharmaceutical products, and

"Whereas, the expense of such advertising is millions of dollars per year, which could be used much more advantageously in medical care and research, and

"Whereas, a national or State clearing committee could be established to investigate new drug claims, and forward to physicians a descriptive card of potentially beneficial drugs, and

"Whereas, the St. Louis County Medical Society of Duluth, Minnesota, a component member of the Minnesota State Medical Society, has made rapid strides toward such a goal; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society go on record as being unanimously in favor of such action; and be it further

"RESOLVED: That a committee be appointed from the membership of the Michigan State Medical Society to contact R. O. Bergan, M.D., Duluth, Minnesota, Secretary of the St. Louis County Medical Society, of this action, and to work further with that Society toward the ultimate goal. Also that said committee report to the Michigan State Medical Society membership through the medium of the JOURNAL, periodically as to the progress being made."

THE SPEAKER: This resolution will be referred to the Reference Committee on Miscellaneous Business.

XII—16. RE REPRESENTATION ON MMS BOARD

D. A. BOWMAN, M.D. [Bay-Arenac-Iosco]: This resolution was approved by the Bay-Arenac-Iosco County Medical Society in June, 1957:

"Whereas, the Michigan Medical Service is a corporation established and operated by the medical profession of Michigan, and

"Whereas, the Michigan Medical Service has been first to pay for services rendered by others than the medical profession, and

"Whereas, there is no moral, legal or political reason for permitting any other groups to enter into the administration and policy making of the Michigan Medical Service; now, therefore, be it

"RESOLVED: That no other groups, professions or representatives of cult shall be appointed or elected to the Board of Directors of Michigan Medical Service either as representatives of the other groups or as public representatives."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations, with emphasis on the "Public Relations."

XII—17. RE SECTION REPRESENTATION IN MSMS HOUSE OF DELEGATES
(Constitution Article VII)

H. F. FALLS, M.D. [Washtenaw]:

"Whereas, the increasing burden of economic and sociologic problems requires the studied judgment of the profession as a whole, and

"Whereas, the present machinery of the Michigan State Medical Society makes it difficult for the specialty groups to voice their opinions; therefore, be it

"RESOLVED: That each specialty section of the Michigan State Medical Society be invited to elect one delegate to the MSMS House of Delegates."

This was referred to the Reference Committee on Constitution and Bylaws.

XII—18. RE INCLUSION OF M.D.s UNDER SOCIAL SECURITY

V. M. ZERBI, M.D. [Washtenaw]:

This resolution is being presented upon instruction of the Washtenaw County Medical Society by a majority vote:

"Whereas, the Washtenaw County Medical Society by majority vote favors the compulsory inclusion of physicians in Social Security, and

"Whereas, the history of the past twenty years indicates that Social Security is here to stay, and

"Whereas, physicians pay the Social Security tax whenever they buy goods or services, but have no prospect of recovery, and

"Whereas, over 50 per cent of physicians are now covered by Social Security; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society declare itself in favor of the compulsory inclusion of physicians in Social Security; and be it further

"RESOLVED: That the delegates to the AMA be instructed to institute similar action in the House of Delegates of the AMA."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

XII—19. RE SEPARATION OF BLUE CROSS AND BLUE SHIELD

E. H. FENTON, M.D. [Wayne]:

"Whereas, Blue Shield is being blamed for the increased cost of hospitalization, and

"Whereas, the public will be best served by demarcation of respective fields of Blue Cross and Blue Shield, and

"Whereas, no necessity exists in fact for the association of the two organizations, and

"Whereas, there is an increased feeling among physicians that such association also is not in the interest of the medical profession; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society go on record as favoring the dissolution of the working arrangement between the two organizations."

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XII—20. RE TRAINING AMBULANCE DRIVERS

A. C. STANDER, M.D. [Saginaw]:

"Whereas, incompetent or careless handling of the injured may produce further injury and jeopardize life, and

"Whereas, the speeding ambulance may lead to further jostling and injury to unsplinted fractures as well as the double jeopardy of further accidental injury, and

"Whereas, this condition can be remedied by adequate first-aid training of ambulance personnel, and

"Whereas, with trained personnel the need for break-neck speed will be less urgent; therefore, be it

"RESOLVED: That the Michigan State Medical Society House of Delegates go on record in favor of some type of regulation of ambulance personnel requiring first-aid training and certification, and also some rules for judicious use of excessive speeds and siren sounds by ambulances; and be it further

"RESOLVED: That a copy of this resolution be sent to those individuals, organizations and authorities as felt advisable by The Council of the Michigan State Medical Society."

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

XII—32. RE PRINCIPLES OF A COMPREHENSIVE MEDICAL SERVICE PLAN

G. H. BAUER, M.D. [Washtenaw]:

The delegation from Washtenaw County has been instructed to submit the following resolution:

"Whereas, there has been an increasing demand for more comprehensive prepayment medical service and an apparent willingness of the public to pay the necessarily higher premium for this service, and

"Whereas, it is in the public interest that physicians maintain their key role in any prepayment plan for the provision of these services; therefore, be it

"RESOLVED: That the Washtenaw County Medical Society recommends to the Michigan State Medical Society that Michigan Blue Cross-Blue Shield develop a comprehensive plan embodying the following principles:

"(1) Outpatient diagnostic and surgical services including laboratory and x-ray.

"(2) Consultation service in the recognized specialties on both outpatient and inpatient basis.

"(3) Unlimited radiologic and laboratory services.

"(4) Coverage of 50 per cent inpatient and outpatient psychiatric care outside governmental facilities.

"(5) A qualified surgical assistant shall be paid a fee.

"(6) Michigan Medical Service fees paid in full only to participating physicians, non-participating physicians to receive 90 per cent of usual fees.

"(7) Acceptance of one equitable fee for service regardless of subscriber's income. Collection by Michigan Medical Service of subscriber's premiums on basis of income of subscriber.

"(8) That the principle of the inclusion of deductible features in this comprehensive plan be considered."

THE SPEAKER: This resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XIII. REPORT OF PERMANENT ADVISORY COMMITTEE ON FEES

By Grover C. Penberthy, M.D.

Before presenting our report, the Committee wishes to read the resolution that was presented by Dr. Fenton of Wayne County last year and approved by the 1956 House of Delegates.

"Whereas, inequities exist in professional fee schedules, and

"Whereas, the monetary value of medical and surgical procedures fluctuates, and

"Whereas, it is impractical to remedy these inequities without considerable study, and

"Whereas, certain dissatisfactions within the profession will be minimized by a continuing consideration of these fee schedules, and

"Whereas, the temporary committee has inadequate time to consider the problem; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society establish a Permanent Advisory Committee on Fees."

Now I shall present the report of the Permanent Advisory Committee on Fees:

This Committee held one meeting during the year. This was devoted to a consideration of those areas to which the Committee should give consideration.

It was felt that this Committee was not charged with the responsibility of developing fee schedules, but rather to review the whole subject of medical fees and to render advice to those groups specifically charged with the setting up of fees for various categories.

The Committee established the following areas for its consideration:

(1) Historical reference to happenings in the past several decades.

(2) The need for maintenance of professional independence on a fee-for-service basis.

(3) The requisite of giving conscientious, fair and honest service to patients.

(4) That, based on our changing economy, constant studies be made of the fee situation in this State, comparable to other states.

(5) That to implement these studies it might be necessary to invoke the services of a full-time professional analyst.

(6) That this Committee welcomes at all times suggestions and advice in order to make information available to the profession on a permanent basis.

Respectfully submitted,

G. C. PENBERTHY, M.D., *Chairman*
J. S. BEER, M.D. M. A. DARLING, M.D.
H F. FALLS, M.D. W. M. LEFEVRE, M.D.
M. L. LICHTER, M.D.

THE SPEAKER: This report will be submitted to the Reference Committee on Reports of Special Committees.

XIV. REPORTS OF STANDING COMMITTEES

XIV—1. POSTGRADUATE MEDICAL EDUCATION

XIV 2.—PREVENTIVE MEDICINE

XIV—3. PUBLIC RELATIONS

XIV—4. ETHICS

XIV—5. LEGISLATIVE

On page 119 of the Handbook you will find the beginning of the reports of the standing committees. I think it would be much easier for you to read those reports at your leisure rather than have all of them read. Unless I hear a dissenting voice, we will proceed along that line.

I would like to ask at this time whether there are any supplemental reports from any of these committees under A, B, C, D and E of the reports of standing committees. Are there any supplemental reports from those committees? If not, all of these reports will be referred to the Reference Committee on Standing Committees.

XV. REPORTS OF SPECIAL COMMITTEES

THE SPEAKER: We shall proceed to Annual Reports of MSMS Special Committees. These reports also are in the Handbook.

XV—1. BEAUMONT

XV—2. SCIENTIFIC RADIO

XV—3. ADVISORY TO WOMAN'S AUXILIARY

XV—4. ADVISORY TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

These reports will be referred to the Reference Committee on Reports of Special Committees.

The meeting was recessed at 4 p.m.

MONDAY EVENING SESSION

September 23, 1957

The meeting reconvened at 8:20 p.m., K. H. Johnson, M.D., Speaker of the House of Delegates, presiding.

XII—21. (Motion) TO APPOINT PARLIAMENTARIAN

W. S. REVENO, M.D. [Wayne]:

I would like to introduce a motion to empower the Speaker of the House of Delegates to appoint a Parliamentarian to sit with him during this 1957 session and to resolve any parliamentary problems that may come up.

I so move.

CHARLES SELLERS, M.D. [Wayne]: Second the motion.

[*The motion was put to a vote and was carried unanimously.*]

THE SPEAKER: The Speaker will appoint the Vice Speaker as Parliamentarian; during the time the Vice Speaker is in the Chair, Dr. Bailey of Wayne will be the Parliamentarian.

XII—22. RE THE COLLECTION OF DUES

C. L. CANDLER, M.D. [Wayne]:

"Whereas, in 1956 the House of Delegates authorized the Michigan State Medical Society to assume the responsibility for membership billing, and

"Whereas, the purpose of the new collection procedure was to handle more expeditiously dues collection and to provide a service to the constituent societies, and

"Whereas, these objectives have been reached in many county medical societies that do not maintain an executive office, and

"Whereas, this billing service has not been helpful in Wayne County but has resulted in innumerable complaints from the membership, a marked decrease in collection, and in additional clerical work; therefore, be it

"RESOLVED: That each county medical society be permitted to decide whether it wishes to avail itself of this billing service of the Michigan State Medical Society; and be it further

"RESOLVED: That county societies who elect to do their own billing be granted the 1 per cent collection fee."

Mr. Speaker, I move the adoption of this resolution.

This was referred to the Reference Committee on Resolutions.

XII—23. RE ANNUAL REGISTRATION OF M.D.'S

L. A. DROLETT, M.D. [Ingham]:

"Whereas, the bulk of the revenue which the Legislature appropriates to the Board of Registration in Medicine is derived from the original ($50 plus) license fees collected from new doctors entering practice, and

"Whereas, it is evident that some new sources of operating revenue must be found for the Board if it is to properly serve the profession and the people of this State; therefore, be it

"RESOLVED: That this House of Delegates respectfully request the Board of Registration in Medicine and appropriate Legislators to review with The Council or its Executive Committee the existing and projected programs and fiscal policies of the Board to enable The Council to recommend changes in the Medical Practice Act which will effect some relief to the new MD's and provide adequate funds for the Board's duties; and be it further

"RESOLVED: That if such legislative changes must necessarily embody a form of annual registration of MD's, that this House of Delegates endorses a fee of $5."

Because this was a part of the report of The Council, I shall refer it to the Reference Committee on Reports of The Council.

XVI. REPORTS OF REFERENCE COMMITTEES

XVI—1. ON OFFICERS REPORTS

CHARLES SELLERS, M.D.:

XVI—1(a) *Report on the President's Address.*—The Reference Committee approved the address of President with great thanks. The House concurred.

XVI—1(b) *Report on President-elects' Address.*—The address of the President-elect, George Slagle, M.D., was approved with high thanks. The House concurred.

XVI—1(c) *On the Report of the Delegates to the American Medical Association.*—The report of the delegates to the AMA was approved and the House concurred.

XVI—1(d) *On the Report of the Woman's Auxiliary.*—The Reference Committee approved the report of the Woman's Auxiliary. The House concurred.

XVI—1(e) *On the Report of the Michigan State Medical Assistants' Society*—The Reference Committee approved the report of the Michigan State Medical Assistants' Society. The House concurred.

XVI—2. ON REPORTS OF STANDING COMMITTEES

E. H. FENTON, M.D.: The Reference Committee on Reports of Standing Committees approved all these reports.

[*The motion was put to a vote and was carried unanimously.*]

XVI—3. ON REPORTS OF THE REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

L. J. BAILEY, M.D. [Wayne]:

The Reference Committee on Special Committees approved the reports from the *Beaumont Memorial Committee*, the *Scientific Radio Committee*, the *Advisory Committee to the Woman's Auxiliary*, and the *Advisory Committee to the Michigan State Medical Assistants' Society*, as printed in the Handbook, pages 147 to 153 inclusive.

XVI—4. ON REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

E. S. PARMENTER, M.D. [*Alpena-Alcona-Presque Isle*]: A resolution was presented by Dr. Falls of Washtenaw County. This resolution was approved for constitutional amendment and a change in the Bylaws.

XVI—4(a). RESOLUTION RE SECTION REPRESENTATION IN MSMS HOUSE OF DELEGATES

(Const. Art. VII Bylaws, Chap. 8, Sec. 1)

We propose the following amendment to the Constitution:

Article VII—House of Delegates—Section 1 should read: "The House of Delegates shall be the legislative body of the Michigan State Medical Society and shall consist of delegates elected by component county medical societies, by the members of the authorized specialty sections and delegates-at-large, as prescribed by the Bylaws."

The addition to the Bylaws is as follows: Chapter 8—House of Delegates—Section 1 (Composition): "The House of Delegates shall be composed of members elected by the component county societies and members of the authorized specialty sections."

The change in the Bylaws will have to lie over until tomorrow, and the constitutional amendment will have to be tabled for one year.

I move the adoption of the Reference Committee's report.

THE SPEAKER: The action of the Reference Committee is to bring up tomorrow, at the next meeting, a change in the Bylaws, and one year for a change in the Constitution. In approving this Reference Committee's report, all you are doing is setting it over for further action. [*Motion was seconded and carried.*]

XVI—4(b). RESOLUTION RE REGULATION OF MEMBERSHIP

(Bylaws Chap. 2, Sec. 1)

E. S. PARMENTER, M.D.: The resolution presented by Dr. E. H. Fenton of Wayne County was disapproved. This resolution asked for a change in the Bylaws. It was disapproved because it is believed to be adequately covered in other changes in the Bylaws which will be presented.

XVI—4(c). RE DISCIPLINE OF MEMBERS

(Bylaws Chap. 6)

A resolution presented by Dr. C. D. Adler, of Wayne County, was also disapproved because it likewise is adequately covered in extensive proposed changes in the Bylaws to be considered.

XVI—4(d). BYLAWS AMENDMENTS TO MEDIATION—ETHICS—GRIEVANCE

E. S. PARMENTER, M.D.: The members of the Reference Committee on Constitution and Bylaws considered a long report submitted to The Council and directly to the members of the House of Delegates. This Committee, headed by Dr. R. J. Hubbell, has worked during the past year on revisions covering Chapters 6 and 7 of the Michigan State Medical Society Bylaws. These Bylaws were printed and sent to all county societies for comment. Only two offered suggested changes which have been incorporated into this report.

The proposed changes as approved by the Reference Committee on Constitution and Bylaws were presented in detail.

SUGGESTED ADDITIONS TO BYLAWS RELATIVE GRIEVANCE COMPLAINTS FROM THE PUBLIC

Chapter 7 Re Grievances of Non-Members Mediation Committees

Section 1, 2, 3, 4, were approved as printed.

At the end of Section 1, add: (f) Committee on Mediation (approved).

Section 7, approved.

MISCELLANEOUS CHANGES IN BYLAWS SUGGESTED

Delete from Chapter 2, Sections 6 and 7. Deletion approved.

Section 1, approved.

Delete from Chapter 10, Section 5, the last sentence (approved).

Proposed Chapter 6—Conduct and Discipline of Members

Section 1, 2, approved; also 3, 4, approved as printed.

Section 5, (deletion of last sentence approved).

Sections 6, 7, 8, approved.

Section 9. Deletion of "and may be represented by counsel" and take out "or by counsel for the component county society.", and add in its place "of the component county society."

Section 10, approved.
Section 11, approved.
Section 12, approved.
Section 13, approved.
Section 14, approved.
Section 15, approved.
Section 16, approved.
Section 17, approved.
Section 18, approved.

J. E. LIVESAY, M.D. [Genesee]: I would like to move that this constitutes a formal presentation of this matter to the House of Delegates.

[*The motion was severally seconded and carried.*]

XII—24. CONSTITUTION ART. X—SECS. 1-2-3. TO MAKE VICE SPEAKER A VOTING MEMBER OF THE COUNCIL AND EXECUTIVE COMMITTEE

The Chair believes this is the proper time to bring up a matter that was presented to the Constitution and Bylaws Committee last year in regard to the Vice Speaker being a voting member of The Council and the Executive Committee. Therefore, with your permission I will read this proposed change, and then it will be your privilege to do with it as you see fit.

"Whereas, the Vice Speaker of the House of Delegates of the Michigan State Medical Society is presently a member of The Council and the Executive Committee but without power to vote, and

"Whereas, The Council, desiring broader representation of the House of Delegates on the Executive Committee, has recommended that the Vice Speaker be given full membership on The Council and the Executive Committee; therefore, be it

"RESOLVED: That the House of Delegates takes action to amend the Constitution and Bylaws to make the Vice Speaker of the House of Delegates a member of The Council and the Executive Committee by amending Section 1, Article X of the Constitution by inserting the words 'and Vice Speaker' after the word 'Speaker'; by amending Section 2, Article X of the Constitution by striking out the words preceding the word 'Speaker' and inserting after the word 'Speaker' the words 'and Vice Speaker'; by deleting Section 3 of Article X of the Constitution and by amending Section 1 of Chapter 9 of the Bylaws by inserting the words 'and Vice Speaker' after the word 'Speaker.'"

W. W. BABCOCK, M.D.: I so move.

H. A. FURLONG, M.D: Second the motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The Vice Speaker assumed the Chair.*]

XVI—5. ON REPORT ON RESOLUTIONS

J. M. WELLMAN, M.D. [Ingham]:

XVI—5(a) *Annual Report of Healing Arts Study Committee.*—The Reference Committee considered the annual report of the Healing Arts Study Committee of 1956-57 and resolution introduced by Dr. John Rodger, Northern Michigan Medical Society, both of these matters relating to the osteopathic problem.

The specific recommendations in the annual report of the Healing Arts Study Committee will be discussed separately. *The first recommendation* is:

(1) "That the Michigan State Medical Society approve medical schools of the University of Michigan and Wayne State University giving courses to osteopaths."

The Reference Committee points out that this is a definite contradiction to the action taken by the AMA in considering the Cline report. Your Reference Committee recommends unanimously that this above recommendation be disapproved.

Before we proceed with these recommendations I would like to read the final paragraph of that report: "The Committee noted with interest the MSMS policy and relationship to other healing arts professions, e.g., chiropodists, optometrists, physical therapists, etc. It did not choose to comment on these on the basis that the situation seems generally well in hand."

Mr. Speaker, I move that the above recommendation of the Healing Arts Study Committee be disapproved.

E. C. LONG, M.D.: I second the motion.

After full discussion the recommendation of the reference committee on Item I was tabled.

SPEAKER LIGHTBODY: *The motion is tabled.*

The Chairman of this Reference Committee will proceed with the second recommendation.

J. M. WELLMAN, M.D.: *The second recommendation* of the Healing Arts Study Committee is as follows:

"That the Michigan State Medical Society delegates to the AMA House of Delegates be instructed to submit a resolution to the AMA House of Delegates at that body's next session, requesting the referral of the problem of MD's-DO's relationship to the individual constituent state medical societies for action by their individual houses of delegates, and that actions, subsequently taken on this question by these houses, be considered ethical in relation to the AMA Principles of Ethics."

Your Reference Committee recommends unanimously that this above recommendation No. 2 be approved, and I so move.

[*The motion was severally seconded, put to a vote and carried unanimously.*]

J. M. WELLMAN, M.D.: *The third recommendation* of the Healing Arts Study Committee is as follows:

"That the Michigan State Medical Society approve consultation between MD's and DO's if and when approved by the American Medical Association."

The present Code of Ethics of the AMA does not permit such consultation. Your Reference Committee did not wish to take any action in this regard predicated upon a change in the present Code of Ethics. Your Reference Committee recommends unanimously that this recommendation be disapproved, and I so move.

S. L. LOUPEE, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

J. M. WELLMAN, M.D.: *The fourth recommendation* of the Healing Arts Study Committee is as follows:

"That the Michigan State Medical Society agree to having its Legislative Committee meet (annually) when necessary with the like Committee of the Michigan Association of Osteopathic Physicians to attempt to iron out any mutual legislative problems."

Your Reference Committee recommends unanimously that this recommendation be approved, and I so move.

L. A. DROLETT, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—5(b) REFERRAL OF HEALING ARTS PROBLEM TO AMERICAN MEDICAL ASSOCIATION

CHAIRMAN LIGHTBODY: We have another resolution here on a subject that sounds like what we just discussed, but I think we would like to have it projected on the screen so we can all see it. Dr. Wellman says he will read it.

J. M. WELLMAN, M.D.: Resolution No. 9, presented by John R. Rodger, M.D., Northern Michigan Medical Society, is as follows:

[*Dr. Wellman read resolution No. 9.*]

J. M. WELLMAN, M.D. [*continuing*]: Your Reference Committee considered this and unanimously recommends approval in its original form.

W. S. JONES, M.D. [Menominee]: I second that.

[*The motion was put to a vote and was carried unanimously.*]

XVI—6 ON SPECIAL MEMBERSHIPS

W. L. BROSIUS, M.D.: Your Reference Committee on Special Memberships wishes to present a partial report, approving memberships as follows. We would like to take these up by class of membership, and vote on them separately.

For *Honorary Membership:* Mr. William J. Burns.

Your Reference Committee recommends adoption of this resolution.

W. S. REVENO, M.D.: I support it.

[*The motion was put to a vote and was carried unanimously.*] [*Applause*]

W. L. BROSIUS, M.D.: The following names were presented for *Life Membership:*

Allegan County.—H. H. Johnson, M.D., Wayland.

Berrien County.—Edward A. Miller, M.D., Berrien Springs.

Gogebic County.—Charles E. Stevens, M.D., Ironwood.

Ingham County.—J. Earl McIntyre, M.D., Lansing.

Ionia-Montcalm County.—Earl P. Bunce, M.D., Trufant; Oscar P. Geib, M.D., Carson City; Alfred E. Hollard, M.D., Belding; Perry C. Robertson, M.D. Ionia.

Kent County.—Earle J. Byers, M.D., Grand Rapids; Ernest W. Dales, M.D., Grand Rapids; Alfred Dean, M.D., Sagola; John Ver Meulen, M.D., Grand Rapids; William R. Vis, M.D., Grand Rapids.

Lenawee County.—W. B. Hornsby, M.D., Clinton; Philip P. Sayre, M.D., Onsted; Chad A. Van Dusen, M.D., Blissfield.

Saginaw County.—Alexander R. McKinney, M.D., Saginaw; John T. Sample, M.D., Saginaw.

Washtenaw County.—Frederick A. Coller, M.D., Ann Arbor; Emory W. Sink, M.D., Ann Arbor.

St. Clair County.—George Van Rhee, M.D., Port Huron.

Wayne County.—Effie E. Arnold, M.D., Detroit; T. H. Edward Best, M.D., Detroit; F. W. Bramigk, M.D., Detroit; Philip H. Broudo, M.D., Detroit; Duncan Campbell, M.D., Detroit; William J. Cassidy, M.D., Detroit; Aaron L. Chapman, M.D., Detroit; Don A. Cohoe, M.D., Highland Park; Ray S. Dixon, M.D., Detroit; Clair L. Douglas, M.D., Detroit; Edward F. Dowdle, M.D., Detroit; Clarence H. Eisman, M.D., Detroit; Ray L. Fellers, M.D., Detroit; William Gramley, M.D., Detroit; Charles W. Husband, M.D., Detroit; Zeno L. Kaminski, M.D., Detroit; Charles S. Kennedy, M.D., Detroit; Hugh A. McFadyen, M.D., Detroit; Harriet E. McLane, M.D., Detroit; Edward J. O'Brien, M.D., Detroit; Jacob R. Rupp, M.D., Detroit; Rene J. St. Louis, M.D., Detroit; Stelios N. Sakorraphos, M.D., Detroit; Simon H. Sauter, M.D., Detroit; Jesse G. Slaugenhaupt, M.D., Detroit; Elisha J. Tamblyn, M.D., Detroit; Delma F. Thomas, M.D., Detroit.

Your Reference Committee recommends the transfer of these members to Life membership. I so move.

CHARLES SELLERS, M.D.: I second the motion.

[The motion was put to a vote and was carried unanimously.]

W. L. BROSIUS, M.D.: For *Retired Membership:*

Oakland County.—Burton M. Mitchell, M.D., Pontiac.

Wayne County.—Roland M. Athay, M.D., Carl C. Birkelo, M.D., Harry G. Clark, M.D., Floyd B. Knapp, M.D., Arlington Lecklider, M.D., Walter H. Squires, M.D., Hugh Stalker, M.D., Henry B. Steinbach, M.D., Cleary N. Swanson, M.D., William A. Thompson, M.D., all of Detroit.

The Reference Committee recommends the transfer of these members to Retired membership, and I so move.

CHARLES SELLERS, M.D.: I second the motion.

[The motion was put to a vote and was carried unanimously.]

W. L. BROSIUS, M.D.: For *Associate Membership:*

Alpena County.—Jerry Miller, M.D., Hillman.

Chippewa County.—LeRoy A. Futterer, M.D., Mackinac Island.

Hillsdale County.—William O. Michel, M.D., Ann Arbor.

Gratiot County.—LeRoy F. Von Lackum, M.D., Alma.

Oakland County.—Juliette Seelye Karow, M.D., Royal Oak.

Washtenaw County.—John N. Bicknell, M.D., George E. Block, M.D., Fred G. Blum, Jr., M.D., Philip D. Brooks, M.D., Donald C. Bullington, M.D., Charles W. Butler, Jr., M.D., C. William Castor, Jr., M.D., William A. Challener, III, M.D., George W. Cheek, Jr., M.D., Alton J. Coppridge, M.D., William M. Cutler, M.D., James H. Geist, M.D., Robert I. Goldsmith, M.D., Carol E. Goodman, M.D., Frank H. Goodrich, M.D., Donald J. Holmes, M.D., Albert S. Jacknow, M.D., Robert S. Jampel, M.D., Edmund M. Krigbaum, M.D., Graydon A. Long, M.D., John C. Nixon, M.D., Gerald A. O'Connor, M.D., Alden R. Parker, M.D., Prasanna K. Pati, M.D., Gus A. Raney, M.D., Melvin J. Reinhart, M.D., F. Dale Roth, M.D., Arthur S. Shufro, M.D., Carlson R. Speck, M.D., Donald Y. Stewart, M.D., Thomas P. Stratford, M.D., Emanuel Tanay, M.D., Ralph W. Theobald, M.D., Robert L. Timmons, M.D., John B. Tisserand, Jr., M.D., John S. Tytus, M.D., John D. Werley, M.D., Donald K. Williams M.D., James H. Winkler, M.D., James A. Wood, M.D., William S. Wilson, M.D.

Wayne County.—Donald R. Brock, M.D., Paul Dzul, M.D., David French, M.D., Eugene P. Frenkel, M.D., Alex Gaynor, M.D., Frank L. Hoagland, M.D., L. W. Hull, M.D., William V. Kyle, M.D., Charles West, M.D., John D. McKinnon, M.D., Donald R. Nielson, M.D., Melvin K. Pastorius, M.D., all of Detroit.

* * *

Report of the Reference Committee was approved.

XVI—7. ON LEGISLATION AND PUBLIC RELATIONS

W. S. REVENO, M.D.: Your Reference Committee on Legislation and Public Relations had five resolutions submitted to it for consideration. The first of these had to do with the expansion of Wayne State University Medical School.

[Dr. Reveno read resolution No. 12.]

XVI—1(a). EXPANSION OF MEDICAL SCHOOL FACILITIES

The Reference Committee noted that a similar resolution was considered a year ago, and there is a comment on it on pages 89 and 90 of the Handbook. May I read that to you also? This refers to a resolution regarding expansion of medical school facilities at Wayne State University.

"Letters have been written to the Governor, the Lieutenant Governor (as presiding officer of the Senate) and the Speaker of the House of Representatives, urging accomplishment of this resolution. A proposal to add to the budget of Wayne State University the sum of $285,650 for expansion of teaching personnel to provide for fifty extra medical students was introduced, but not adopted by the Legislature."

It seemed to the Reference Committee that the resolution offered at this time is an effort to reintroduce similar action in the Legislature and accordingly this resolution was approved by the Reference Committee.

I therefore move the adoption of this resolution.

C. L. WESTON, M.D. [Shiawassee]: I second the motion.

[The motion was put to a vote and was carried unanimously.]

XVI—7(b). CREATION OF STUDY COMMITTEE ON PRACTICE PRIVILEGES IN PUBLIC HOSPITALS

W. S. REVENO, M.D.: The Reference Committee, after due discussion, felt that it was entirely out of order to bring the Medical Practice Act into this situation, and after discussion with Dr. Furlong the Reference Committee reformulated this resolution, particularly the last paragraph, which I shall read to you:

"RESOLVED: That the Oakland County Medical Society requests The Council of the Michigan State Medical Society to prepare legislation that will establish the right of public hospitals to control medical practice within their institution."

The Reference Committee approved this resolution as reworded, and I move its adoption as amended.

J. A. WITTER, M.D. [Wayne]: I second the motion. The substitute resolution was carried.

THE SPEAKER: You are speaking against adoption

of the rephrased resolution as well as the original resolution.

XVI—7(c). RE REPRESENTATION ON MMS BOARD

[*Dr. Reveno read resolution No. 16.*]

W. S. Reveno, M.D.: The Reference Committee disapproved this resolution for the following reasons:

(1) It does not constitute good public relations to go on record as opposing the groups referred to.

(2) A nominee would in the present circumstances probably have small chance of election.

(3) The resolution is out of line with the statute establishing Michigan Medical Service.

The Reference Committee therefore recommends disapproval of this resolution, and I so move.

C. L. Weston, M.D.: I second the motion.

O. J. Johnson, M.D.: I question the opinion of the Reference Committee on the Medical Practice Act that he has mentioned, that is, the enabling Act. Perusal of that Act does not show anything that would make such action contrary. However, I do feel that your statements that it would be poor public relations and probably the nominee would not get by this body, are correct. I don't think it would be illegal, however.

[*The motion to disapprove was put to a vote and was carried unanimously.*]

XVI—7(d). INCLUSION OF MD'S UNDER SOCIAL SECURITY

W. S. Reveno, M.D.: The next resolution was submitted by Washtenaw County Medical Society.

Your Reference Committee disapproves this resolution principally because extension of social benefits leads to wider socialization. The immorality of the entire Social Security Act was emphasized in the discussion; and while by objecting to social security we are penalized by greater taxes and are denied certain questionable benefits, we are rendering a service as a minority in opposition.

The Reference Committee unanimously DISAPPROVED this resolution. I move adoption of the Reference Committee's recommendation.

XVI—7(e). TRAINING OF AMBULANCE DRIVERS

W. S. Reveno, M.D.: The last resolution considered was one that has to do with first-aid training for ambulance drivers and regulation of ambulance speed and sound. I shall read the "Resolved" portion.

Your Reference Committee approved this resolution and recommends its adoption. I so move.

C. L. Weston, M.D.: Second the motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The meeting adjourned at 11:30 p. m.*]

TUESDAY MORNING SESSION

September 24, 1957

The meeting reconvened at 10 a.m., K. H. Johnson, M.D., Speaker of the House of Delegates, presiding.

XVI—4(c).—BYLAW AMENDMENT M-E-G

E. S. Parmenter, M.D.: The members of the Reference Committee on Constitution and Bylaws considered a long report submitted to The Council and directed to the members of the House of Delegates. This Committee, headed by Dr. R. J. Hubbell, has worked during the past year on revisions covering Chapters 6 and 7 of the Michigan State Medical Society Bylaws. These Bylaws were printed and sent to all county societies for comment. Only two offered suggested changes, which have been incorporated into this report. The proposed changes as approved by the Reference Committee on Constitution and Bylaws are as follows.

In handling this, perhaps we may handle it according to the chapters involved. I will read the corrections and changes covering the chapters and ask for your approval.

Suggested additions to Bylaws relative to grievance complaints from the public, covering Chapter 7, regarding grievances: From the sheets that you were given, Sections 1, 2, 3 and 4 were approved as printed. At the end of Section 1 add one line under (f), Committee on Mediation. This was approved.

Miscellaneous changes in Bylaws suggested: Delete from Chapter 2, Sections 6 and 7. This deletion was approved by your Reference Committee. Here you find reference to the resolution presented by the Wayne delegation, which we mentioned yesterday as being disapproved.

Mr. Speaker, at this point I move that this section of the report be approved.

R. W. Teed, M.D.: I second that.

[*The motion was put to a vote and was carried unanimously.*]

E. S. Parmenter, M.D.: Section 1. Delete from Chapter 10, Section 5, the last sentence.

[*The motion to approve was made, seconded and carried unanimously.*]

E. S. Parmenter, M.D.: Chapter 6, Conduct and Discipline of Members. Section 1, Standards of Conduct. Section 2, Grounds for Discipline. Section 3 on page 15 of the green sheets, Discipline—Definition and Purpose. Section 4, Authority to Discipline. These have all been approved as printed.

Section 5, Ethics Committee. With the addition of the last sentence, "It may be assisted by legal counsel for its component county society," delete that last sentence as printed on the green sheet. With that deletion, Section 5 was approved.

Sections 6, 7 and 8 were approved as printed.

Section 9, Answer and Formal Hearing. In the middle of the paragraph, in the ninth line, "It shall be the duty of the respondent to appear before the ethics committee in person at the time and place specified in such notice." Delete "and may be represented by counsel." "At such formal hearing it shall be the duty of the respondent to answer fully and fairly all questions pertaining to his conduct which may be put to him by any member of the committee." Delete the following words, "or by counsel for the component county society," and substitute "as put to him by members of the committee of the component county society."

With those deletions and additions, Section 9 was approved.

Mr. Speaker, I move the adoption of this Section.

J. E. Livesay, M.D.: I second that.

The Speaker: If you vote in favor of the motion you will delete all reference to the presence of legal counsel in these matters. There will be no counsel, legal or otherwise.

[*The motion was put and carried.*]

E. S. Parmenter, M.D.: Continuing with Chapter 6, Sections 11, 12, 13, 14, 15, 16, 17 and 18 are all approved as printed.

Mr. Speaker, I move that these be approved.

R. W. Teed, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—4(a).—SECTION REPRESENTATION IN MSMS HOUSE OF DELEGATES

(Const. Art. VII and Bylaws, Chap. 8, Sec. 1)

E. S. Parmenter, M.D.: A resolution was presented by Dr. Falls of Washtenaw County. The constitutional amendment asked that a representation in the House of Delegates be given to each of the specialty groups.

Our recommendation is an addition to constitution Article VII, a constitutional amendment to Article VII, regarding the House of Delegates.

Section 1 shall read: "The House of Delegates shall be the legislative body of the Michigan State Medical Society and shall consist of delegates elected by component county medical societies by the members of the authorized specialty sections, and delegates-at-large as prescribed by the Bylaws."

All that is added is "by members of the authorized specialty sections of the State Society." You will find that on the first pages of the Constitution.

Mr. Speaker, I move the adoption of this resolution.

H. F. FALLS, M.D.: I second that motion.

THE SPEAKER: It is the ruling of the Chair that this suggestion for constitutional amendment will be laid over for one year in accordance with the MSMS Constitution.

E. S. PARMENTER, M.D.: There were two resolutions [XVI-4(b) and XVI-4(c)], one presented by E. H. Fenton, M.D., of Wayne County, and one by Sidney Adler, M.D., of Wayne County, which were considered. Thinking that they were completely covered in this larger area that we have discussed and passed upon this morning, the recommendation of the Reference Committee is that these two resolutions **be disapproved.**

I so move.

[*The motion was seconded and carried.*]

XII—25. PILOT STUDY OF INSURANCE REPORTING

A. C. STANDER, M.D.: I would like to present a resolution.

"Whereas, there are more types of insurance reporting forms than insurance companies, and

"Whereas, much of the information requested is frequently not pertinent to the care of the patient, and frequently utilizes the physician for acquiring information that might well be part of the company's responsibility, and

"Whereas, the Health Insurance Council has developed group insurance forms: Attending Physician's Statement G D-1; Attending Physician's Supplementary Statement G DS-1; Surgeon's Statement G S-1, and

"Whereas, at a meeting of the Saginaw County Medical Society the Society went on record as being willing to undertake a pilot study as a typical county in the State of Michigan; therefore, be it

"RESOLVED: That this House of Delegates goes on record as approving this pilot study of the Saginaw County Medical Society."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

XII—26. RESOLUTION RE STUDY OF THIRD MEDICAL SCHOOL FOR MICHIGAN

R. A. RASMUSSEN, M.D.: Mr. Speaker, I would like to present a resolution:

"Whereas, there is a recognized need for additional training facilities for medical doctors, and

"Whereas, the development of such facilities requires much advance planning, and

"Whereas, medical educators believe that there are adequate clinical facilities and medical personnel in the Grand Rapids area; therefore, be it

"RESOLVED: That the Michigan State Medical Society urge the State Legislature by appropriate action to investigate the feasibility of development of such a medical school in Grand Rapids."

This was referred to the Reference Committee on Legislation and Public Relations.

XII—27. RESOLUTION RE WOMAN'S AUXILIARY SPONSORSHIP OF FREEDOM ESSAY CONTEST

R. F. FENTON, M.D.:

"Whereas, the Michigan State Medical Society has frequently emphasized its avowed purpose of doing whatever it can to promote the American way of life, and

"Whereas, the retiring President of the Woman's Auxiliary to the Michigan State Medical Society has requested advice as to projects it might undertake; be it

"RESOLVED: That this House of Delegates suggest that they adopt sponsorship of the AAPS Freedom Essay Contest, and encourage their component county societies to implement this program locally."

This was referred to the Reference Committee on Officers' Reports.

XII—28. RE COMMENDATION TO L. R. LEADER, M.D., DETROIT

K. T. MCGUNEGLE, M.D.:

"Whereas, the work of Dr. Luther R. Leader as team physician to the Detroit Tigers has been of great value to the profession in the field of public relations; therefore, be it

"RESOLVED: That the House of Delegates commend Dr. Leader for his willingness to have undertaken this task."

This was referred to the Reference Committee on Legislation and Public Relations.

XII—29. RE RECOMMENDATION TO JOINT ACCREDITATION COMMITTEE TO ESTABLISH NEW SECTION ON SPECIAL SERVICES

C. I. OWEN, M.D.:

"Whereas, there has been increasing identification with the hospital facility those medical services which require the use of paramedical personnel, and

"Whereas, physicians are legally and ethically responsible for the actions of our technical groups, not the hospital administration, and

"Whereas, this matter has been recently forcibly called to the attention of the Michigan State Medical Society through the action of the Michigan Hospital Service in extending their contract to types of outpatient services which are medical in nature; it is

"RESOLVED: That the Michigan State Medical Society delegates to the AMA House of Delegates be instructed to recommend the establishment of a Section on Special Services through the AMA representation to the Joint Accreditation Committee, and that such a Section on Special Services shall include pathologists, radiologists, anesthesiologists, physiatrists and psychiatrists in hospital staff organization, in addition to the present three Sections—Medicine, Surgery and Obstetrics—in order that complete and unbiased medical care representation will be had at the hospital staff level."

XII—30. ADDING PHYSIATRISTS IN PRESENT MSMS R-A-P SECTION

"Whereas, the Michigan Academy of Physical Medicine and Rehabilitation is constituted of a group of specialists, doctors of medicine, and

"Whereas, these doctors of medicine bear an analogous relationship with the hospital and with their paramedical personnel as do the pathologists, radiologists and anesthesiologists; it is

"RESOLVED: That the physiatrists be included in the Section of the Michigan State Medical Society composed of pathologists, radiologists and anesthesiologists."

These resolutions were referred to the Reference Committee on Resolutions.

XII—31. MSMS ADVISORY COMMITTEE TO MMS

E. G. KRIEG, M.D.: Mr. Speaker, I would like to present this resolution on prepaid health insurance plans.

"Whereas, a tremendous amount of information on

prepayment health insurance has been acquired by various committees and surveys, and

"Whereas, this information will influence the character and extent of coverage to be offered, and

"Whereas, the large majority of members of this House of Delegates will not have sufficient time during this session to digest the information gathered; therefore, be it

"RESOLVED: That all available information collected by committees and surveys on prepayment health plans be turned over to the executive group of Michigan Medical Service, represented by Mr. Jay Ketchum, with instructions to draw up any policy or policies to contain the desired protection consistent with the information obtained in these studies, and consistent with good business principles of American enterprise, particularly the noninterference with doctor-patient relationship as far as that may be possible; and be it further

"RESOLVED: That Drs. Max Lichter, C. I. Owen and G. W. Slagle and other interested parties deemed advisable by The Council of the Michigan State Medical Society be appointed in an advisory capacity to Mr. Jay Ketchum and his staff."

THE SPEAKER: This resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XVI—3(b). PERMANENT ADVISORY COMMITTEE ON FEES

L. J. BAILEY, M.D.: The Reference Committee received a report from the Permanent Advisory Committee on Fees. The report of this Committee was accepted with reservations.

Your Reference Committee notes that the intention of the resolution calling for the formation of this Committee provided for a continuing study on fees in order that this Committee, which is advisory, be in a position to advise.

From the report submitted we note that no such study has been initiated, but rather that the one meeting was organizational in nature and indicated a desire on the part of the Committee for further directive.

We recommend that this House direct the continuing study of fees, which we believe to have been the duty of this Committee, in order that it might be clearly advised as to its duties.

I move the adoption of this supplemental report of the Reference Committee.

P. C. GITTINS, M.D. [Wayne]: I second it.

[*The motion was put to a vote and was carried unanimously.*]

XVI—8(a). ESTABLISHMENT OF FULL-TIME CHAIRS OF PREVENTIVE MEDICINE AND PUBLIC HEALTH IN TWO MEDICAL SCHOOLS

C. W. OAKES, M.D. [Huron]: Our Reference Committee had two resolutions submitted to it. One was introduced by the delegate from Washtenaw County. In going over it we found that it was incomplete, and so we went over it with the person who introduced it, and had it rewritten. The "whereas" phrases mention the need of a Chair in Preventive Medicine in medical schools. The meat of the resolution is in the "Resolved" portion. May I read the "Resolved" section.

"RESOLVED: That the Michigan State Medical Society House of Delegates request that The Council of the Michigan State Medical Society suggest the establishment of a full-time Chair of Preventive Medicine and Public Health be considered by each of the two medical schools located in the State of Michigan."

Your Reference Committee approves the resolution as reworded, and moves its adoption.

O. K. ENGELKE, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—8(b). DISTRIBUTION OF INFLUENZA VACCINE

C. W. OAKES, M.D.: The second resolution is in regard to the Asiatic flu vaccine. Our Reference Committee was unable to verify the statement that the local postmaster may order Asiatic flu vaccine direct from the manufacturer, as stated in the resolution.

The Reference Committee feels that this resolution should be referred to The Council of the Michigan State Medical Society for investigation and action if warranted.

I so move.

R. W. TEED, M.D.: I second the motion.

[*The motion was carried.*]

XVI—9. ON MISCELLANEOUS BUSINESS

W. F. MERTAUGH, M.D. [Chippewa-Mackinac]: The report of the Reference Committee on Miscellaneous Business is as follows:

XVI—9(a). FEDERATED FUND RAISING

On resolution No. 5, "Fund Raising Drives," the Reference Committee approves the resolution in principle.

I move adoption of this resolution.

[*The motion was severally seconded, was put to a vote and was carried unanimously.*]

XVI—9(b). CREATION OF NATIONAL OR STATE CLEARING COMMITTEE TO INVESTIGATE NEW DRUG CLAIMS

W. F. MERTAUGH, M.D.: Reporting on resolution No. 15, "Clearinghouse for Drugs," the Reference Committee disapproves this resolution, and recommends that the delegate presenting this resolution obtain more explicit data and resubmit such data at a later time if he so desires.

I move adoption of this portion of the report.

J. E. LIVESAY, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The meeting recessed at 11:40 a.m.*]

TUESDAY AFTERNOON SESSION

September 24, 1957

THE SPEAKER: It is my very distinct pleasure and privilege as Speaker of this House to present to you now the man whom you have chosen to represent you as Physician of the Year for 1957. Dr. Paul Van Riper, of Champion. I shall ask Dr. Narotzky to bring Dr. Van Riper to the platform.

[*The audience arose and applauded.*]

THE SPEAKER [continuing]: Dr. Van Riper, we are indeed happy to welcome you here. We hope you will make yourself at home. You not only represent yourself, but you represent a great many doctors of medicine in this State who are very proud of what you have done. Would you care to say a few words?

PAUL VAN RIPER, M.D.: I was told that, above all, I should not make a speech. My being selected was very good news. I do wish to express my thanks for the signal honor that has been conferred upon me. It was unexpected. Until yesterday afternoon I didn't have an inkling of anything like this.

I wish to thank you all for the kind gesture toward me. Thank you. [*Applause*]

THE SPEAKER: Now I should like the House to go into a Committee of the Whole for just a minute. We have here a very special resolution which has been submitted by the regional delegates from the fourth estate, which I would like to read to you:

"Whereas, the problem of the non-participating physician has been a matter concerning us in Blue Shield, and

"Whereas, William J. Burns has been elected to Hon-

orary membership in the Michigan State Medical Society, therefore be it

"RESOLVED: That if William J. Burns is found to be conducting himself other than as a participating physician in Blue Shield, his black bag, stethoscope and all his bills will be confiscated."

May I hear a vote of approval? [*Laughter and Applause*]

XVI—7(f). COMMENDATION TO L. R. LEADER, M.D., DETROIT

W. S. REVENO, M.D.: Two additional resolutions were presented to the Reference Committee this morning for its consideration. The first of these is resolution re L. R. Leader, M.D. The Reference Committee is unanimous in favor of this resolution, and I therefore move its adoption.

M. A. DARLING, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—7(g). STUDY OF NEED FOR THIRD MEDICAL SCHOOL IN MICHIGAN

[*Dr. Reveno read the "Resolved" portion of resolution No. 31.*]

W. S. REVENO, M.D.: While the Reference Committee believes that the establishment of another medical school is in order and that it might properly be located in Grand Rapids, it does not feel that this is the time to take action regarding such a project. Rather, it would be more appropriate to expand presently existing facilities to meet the problem of training more physicians.

The Reference Committee therefore *disapproves* this resolution. I move the adoption of this action.

L. J. BAILEY, M.D.: I support the motion.

[*The motion to disapprove was carried.*]

XVI—5(c). COLLECTION OF DUES

J. M. WELLMAN, M.D.: Your Reference Committee on Resolutions considered resolution No. 28, introduced by Dr. Candler, of Wayne, relative to the collection of dues. I shall read the "Resolved" portion of this resolution. (Read portion.)

The House of Delegates in 1956 adopted the present method of collection of county, State and AMA dues by a method of billing from the headquarters office in Lansing, by approving a recommendation to this effect which was submitted in the report of The Council.

Information was furnished your Reference Committee that this method of collection of dues in Wayne County has resulted in problems of billing and collection, and a considerable number of complaints from the members of that County Medical Society, and a substantial loss in percentage of dues collected.

It was also pointed out to the Reference Committe that the present method of collection of dues has resulted in a loss of income from the Wayne County Society to the State Medical Society.

In consideration of these facts, your Reference Committee recommends the adoption of this resolution as submitted.

I so move, Mr. Speaker.

F. P. RHOADES, M.D. [Wayne]: I second that motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—5(d). PILOT STUDY OF INSURANCE REPORTING FORMS

J. M. WELLMAN, M.D.: Your Reference Committee next considered resolution No. 30, introduced by A. C. Stander, M.D., of Saginaw, relative to a pilot study on standard insurance forms.

Your Reference Committee recommends the adoption of this resolution, and I so move.

C. W. OAKES, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—5(e). RECOMMENDATION TO JOINT ACCREDITATION COMMITTEE TO ESTABLISH NEW SECTION ON SPECIAL SERVICES

J. M. WELLMAN, M.D.: Next was resolution No. 34, introduced by Dr. Owen, of Wayne, entitled "Section on Special Services."

Your Reference Committee feels, first, that this resolution is too inclusive; second, that it does not represent the formal opinion of the various groups mentioned in the resolution; third, that the editor of the resolution is not cognizant of the extensive financial support that is required by each member organization represented on the Joint Commission on Accreditation.

For these reasons your Reference Committee recommends unanimously that this resolution be disapproved, and I so move.

R. W. TEED, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—5(f). ADDING PHYSIATRISTS IN PRESENT MSMS R-A-P SECTION

J. M. WELLMAN, M.D.: Resolution No. 35, introduced by Dr. Owen of Wayne, was entitled, "Section Affiliation for Physiatrists."

[*Dr. Wellman read the "Resolved" portion of resolution No. 35.*]

J. M. WELLMAN, M.D. [continuing]: Your Reference Committee recommends that this resolution be *disapproved*, and suggests that this matter might be submitted to the Section on Radiology, Pathology and Anesthesiology of the Michigan State Medical Society for consideration.

Mr. Speaker, I move the adoption of this recommendation.

F. P. RHOADES, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The Vice Speaker assumed the Chair.*]

CHAIRMAN LIGHTBODY: Dr. Furlong, will you present the report of the Reference Committee on Reports of The Council?

XVI—10. ON REPORTS OF THE COUNCIL
XVI—10(a). ANNUAL REPORT OF THE COUNCIL

H. A. FURLONG, M.D.: Your Reference Committee on reports of The Council has held two rather long sessions at which all members were present. In considering the splendid annual report of The Council, the Reference Committee would like to comment on several items as follows:

On page 52 of the financial report, the statement is made that dues on the basis of $28.50 per member is allocated to the General Fund. Lest there be some confusion, the Reference Committee points out that of the $55 annual dues paid by members of the Society, only $28.50 are allocated to the General Fund, but the balance of dues are allocated to the Public Education Reserve, the Public Education Account, the Public Service Account, the Professional Relations Account, the present Building Maintenance Fund, and to a new MSMS Headquarters Fund. The total amounts are as indicated in the report.

In the report of THE JOURNAL, the Reference Committee wishes to commend the JOURNAL of the MSMS on its new format and on the continued excellence of its editorials and scientific articles.

The Organization section: The Reference Committee wishes to express special approval of The Council's

action in (1) the creation of the position of Director of Scientific Activities, and (2) the creation of the position of Assistant Editor of THE JOURNAL, and especially the fortunate choice of Dr. Louis J. Bailey of Detroit.

The achievements of the Public Relations Program are to be especially commended for their excellence.

The Reference Committee takes cognizance of the splendid program of the Woman's Auxiliary, and extends its most hearty congratulations to this organization.

In the report on the contact with governmental agencies, it should be brought to the attention of the House of Delegates that The Council welcomes suggestions from the general membership of the MSMS for any suggestions that will improve the Medicare program. The Reference Committee suggests that the delegates call the attention of their county medical societies to this program, and that suggestions for its improvement should be transmitted to The Council prior to the time of renegotiations of the new contract in March, 1958. The Reference Committee is well aware of the many difficulties connected with the functioning of the Medicare program.

In the report of the Committee on the Study of the Basic Science Acts, a minor typographical error occurred in the tabulation in the middle of page 70. This should read "7 chiropractors—1 per cent" instead of the "7 per cent" as indicated.

The attention of the House of Delegates is directed to the report of the Committee on Courses on Medical Economics and Ethics, and particularly to the paragraph on the bottom of page 73. It is highly desirable of establishing a course in medical ethics and economics at Wayne State University similar to that already provided at the Medical School of the University of Michigan. This is a matter of great importance and should be referred to the appropriate committee for action.

The Reference Committee feels that commendation is due to the fine work of the many committees that have been appointed by The Council during the past year. There are many items in this report which the Reference Committee probably should mention. Due to the limitations of time we can only recommend that this splendid report be read in its entirety and called to the attention of the component county medical societies, and to the various committees the Reference Committee extends its congratulations.

The Reference Committee acted upon the recommendations of The Council as follows:

(1) That The Council be authorized to send MSMS representatives to Washington, D. C., in 1958 on the occasion of the Annual Michigan Day, as recommended by last year's House of Delegates. The Reference Committee recommends approval of this recommendation.

The Reference Committee moves that this recommendation be adopted.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

H. A. FURLONG, M.D.: The second recommendation of The Council:

(2) That serious consideration be given to the Committee on Mediation, Ethics and Grievances. While this matter has been presented by another committee to the House of Delegates, this Reference Committee recommends approval of the recommendation. I so move.

J. A. KASPER, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

H. A. FURLONG, M.D.: Recommendation No. 3: That the Legislative Committee's resolution regarding re-registration of doctors of medicine be approved.

The Reference Committee approves of the matter of annual re-registration of doctors of medicine. The recommendations of the Committee will be presented when the matter of resolution No. 29 is presented for action.

Recommendation No. 4: The Council recommends that the Michigan State Medical Society dues for 1958, for one year only, be increased $50 to raise sufficient funds to start the MSMS building as soon as possible.

This is where the Reference Committee went into a hassle. [*Laughter*] In considering this recommendation of The Council we also, at the same time, considered two resolutions that were presented to the Reference Committee. I will read the "Resolveds."

[*Dr. Furlong read the "Resolved" portions of resolutions introduced by Drs. Thorup and Babcock.*]

The Reference Committee spent considerable time in discussion of this matter. We were fortunate to have before us several members of the staff and The Council to give us advice.

It is the feeling of the Reference Committee that these two resolutions should be disapproved, and the Reference Committee suggests the following plan for the financing of the new MSMS headquarters:

That an assessment of $5 be levied upon each member for the year 1958.

That an assessment of $5 be levied upon each member for the year 1959. (That is an additional $5 to the amount already levied.)

That $10 be assessed for the year 1960.

That $10 be assessed for the year 1961. (In other words, in 1960 and 1961 the dues would be $15. That totals in those four years the $50 recommended by The Council. That would give the headquarters, we feel, adequate time for planning and building of the headquarters. It will spread it over a four-year period and will obviate any difficulty that some of the component societies may encounter because of their present plans.)

I would like to move the disapproval of the two resolutions and the acceptance of the plan suggested by the Reference Committee for the raising of the money to finance the new headquarters.

W. W. BABCOCK, M.D.: I second the motion.

E. S. PARMENTER, M.D.: I would like to ask that the method of assessment be repeated, please.

H. A. FURLONG, M.D.: You understand, Doctor, that a $5 increase in dues was passed last year. It is our idea that that $5 would be carried on into the next four years. In addition, in 1958 an additional $5 would be raised, which would make the dues increase $10. The same would apply in 1959; in other words, another $5 would be added to the $5 already levied. In 1960 and 1961, in addition to the $5 already levied, an additional $10 would be levied, which would make the total of $50 recommended by The Council.

Is it clear?

CHAIRMAN LIGHTBODY: Do you refer to this as an assessment or an increase in dues?

HARVEY C. HANSEN, M.D. [Calhoun]: Is this presented as a motion?

H. A. FURLONG, M.D.: We have referred to this as an assessment. We discussed the matter at great length, and it was the feeling of the Reference Committee and those who appeared before it that it would be best to call this an assessment rather than an increase in dues.

HARVEY C. HANSEN, M.D.: It appears that the motion suggested by the Chairman of the Reference Committee was that we deny the two resolutions and vote on those at the same time we approve this additional assessment. I think they are two separate motions and should be voted upon separately.

CHAIRMAN LIGHTBODY: The motion can be divided if the delegates so desire.

S. E. ANDREWS, M.D. [Kalamazoo]: I object to calling it an assessment, because I understood that an assessment is a taxable thing, while one may deduct

dues from one's income tax. It would seem that the net result would be quite a lot different. If you call it "dues," that's fine; but if you call it an assessment, it is going to cost us more.

CHAIRMAN LIGHTBODY: I will ask the Chairman of the Reference Committee to speak to that point.

H. A. FURLONG, M.D.: It was the consensus of the Reference Committee that that probably didn't make any difference, whether you call it "assessment" or "dues" as far as tax purposes are concerned. If there is someone here who can give us a better opinion than that, we will be very glad to receive it.

CHAIRMAN LIGHTBODY: I would like to ask if the delegates would like to divide this motion or vote on it as made by the Chairman of the Reference Committee.

O. J. JOHNSON, M.D.: Dr. Babcock introduced a resolution asking that estimates be made on how much is going to be necessary for this building. I think that is only a sound practice. In essence we are saying, "Here is $300,000 plus what we already have in the kitty. Go head and spend that much money."

We have no idea how much the building would cost. Apparently the plans have not been drawn. An option has not been taken on any property. We don't know what quarters are necessary.

I move that we vote on the two resolutions separate from the recommendation of the Reference Committee.

[The motion was severally seconded, was put to a vote, and was carried.]

XVI—10(b). PROPOSED INCREASE IN DUES FOR BUILDING FUND (THORUP)

CHAIRMAN LIGHTBODY: Now I will ask the Chairman of the Reference Committee to make a motion to disapprove the first resolution, namely, that presented by Dr. Thorup, and we will discuss each one separately.

H. A. FURLONG, M.D.: The Reference Committee recommends the disapproval of Resolution No. 1, presented by Dr. Thorup of Berrien County.

The motion is to disapprove this resolution, and I so move.

[The motion was severally seconded, put to a vote and carried unanimously.]

XVI—10(c). PROPOSED INCREASE IN DUES FOR BUILDING FUND (BABCOCK)

CHAIRMAN LIGHTBODY: We will proceed with the second resolution, presented by Dr. Babcock.

H. A. FURLONG, M.D.: The Reference Committee recommends the **disapproval** of this resolution for the reasons stated above, and I so move.

[The motion was severally seconded.]

W. W. BABCOCK, M.D.: For the record, I wish to endorse the action of the Reference Committee, and ask that my resolution be disapproved. The reason is as follows:

I was at the Reference Committee meeting at 1 a.m. this morning, and we talked this over. The State Council has really gone along. We all need and want new headquarters. Headquarters needs money to start buying land, getting an architect and doing the preliminary work.

By the compromise suggested by the Reference Committee, I feel no severe hardship will be laid on anyone, and I am certain that next year plans and specifications—ideas, and the like—will be submitted to the House of Delegates by The Council. I think we can certainly trust them to that extent.

CHAIRMAN LIGHTBODY: Thank you, Dr. Babcock. The question is called for.

[The motion was put to a vote and was carried unanimously.]

XVI—10(a). ANNUAL REPORTS OF THE COUNCIL (CONTINUED)

CHAIRMAN LIGHTBODY: We shall now proceed to the recommendation of the Reference Committee relative to the assessment of money on a graduated scale from 1958 to 1961.

H. A. FURLONG, M.D.: The Reference Committee suggests the following plan for the levying of funds for the MSMS headquarters: That an assessment of $5 be levied upon each member for the year 1958, in addition to the $5 already levied; that an assessment of $5 be levied upon each member for the year 1959 in addition to the $5 already in force; that $10 be assessed for the year 1960 in addition to the $5 already levied; that $10 for the year 1961 be levied in addition to the $5 already in force, which over a period of four years makes the $50 increase in dues recommended by The Council.

The Reference Committee recommends approval of this suggestion, and I so move.

F. P. RHOADES, M.D.: I second the motion.

[The motion was put to a vote and was carried.]

XVI—10(d). ANNUAL REGISTRATION OF M.D.'s

H. A. FURLONG, M.D.: Resolution No. 29 was submitted to the Reference Committee for consideration.

The Reference Committee also spent considerable time in discussing this matter. It was discussed at some length with the Chairman of the Legislative Committee. It was pointed out to the Reference Committee that the time has arrived when the annual registration of doctors will probably be imposed. Some rather fantastic figures were quoted as to the amounts that were considered last year, I would say up to $50.

We are in the position now of having to give our Legislative Committee considerable backing, and we feel quite confident that, whether we like it or not, annual registration of doctors will be enforced in the next session of the Legislature, and that we might as well have this thing done to our liking.

The Reference Committee agrees with the general program of annual re-registration of doctors, but would like to make this recommended change in this resolution. I will read the last "Resolved":

"RESOLVED: That if such legislative changes must necessarily embody a form of annual licensure for M.D.'s, that this House of Delegates endorses a fee of $5."

The Reference Committee recommends that this wording be changed by inserting the words "not to exceed" before the figure of $5.

The Reference Committee moves the adoption of this amended recommendation.

R. W. TEED, M.D.: I second that.

[The motion was put to a vote and was carried unanimously.]

XVI—10(a). ON REPORTS OF THE COUNCIL (CONTINUED)

H. A. FURLONG, M.D.: The supplemental report of The Council was submitted to the Reference Committee for consideration. The Reference Committee made no changes in the supplemental annual report of The Council as submitted. However, there were two additional recommendations made by The Council.

Recommendation No. 5: "That The Council be authorized to pursue its study of group life insurance, to the end that MSMS can offer as an added benefit of membership the best program tailored to the needs of Michigan's medical men."

The Reference Committee moves approval of this recommendation of The Council.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Recommendation No. 6: "That The Council be authorized to arrange councilor conferences prior to the annual session, to continue communications with and impart information to the membership."

The Reference Committee approves this recommendation of The Council, and I so move.

J. A. KASPER, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—10(e). STUDY OF RELATIVE VALUE SCHEDULE OF SERVICES

H. A. FURLONG, M.D.: Resolution No. 14 was submitted by Ingham County and was considered by the Reference Committee. I am sorry I don't have it in my hand, but it had to do with a matter that is under study at the present time by the Committee on Medical Service and Prepayment Insurance.

We recommend disapproval of this resolution for that reason. Perhaps Miss Schulte has a copy of that resolution.

[*Dr. Furlong read the "Resolved" portion of resolution No. 14.*]

Your Reference Committee considered this matter. Because it is a matter that is already being studied by another committee, namely, the Committee on Medical Service and Prepayment Insurance, your Reference Committee recommends **disapproval** of this resolution.

I so move.

[*The motion was severally seconded.*]

H. W. HARRIS, M.D. [Ingham]: This resolutoin was not introduced without considerable forethought. It was introduced with the idea of augmenting the work of the Committee headed by Dr. Slagle relative to prepaid insurance.

It is unfortunate that this resolution comes up at this time, because Dr. Slagle's resolution is in the hands of another committee, and no one knows what their recommendation will be nor how the House will deal with it.

Therefore, rather than disapproving this resolution, I would like to move that it be laid on the table until the other committee has reported. If the measures recommended herein are covered by that committee's report, then this is of no value and can be deleted. However, to disapprove it now may mean this House will be without such a resolution, which I believe to be in the interest of and, in fact, the desire of many of the members.

R. W. TEED, M.D.: I support the motion *to lay this on the table.*

[*The motion was put to a vote and was carried unanimously.*]

CHAIRMAN LIGHTBODY: We will now call for the report of the Reference Committee on Medical Service and Prepayment Insurance.

XVI—11. ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

XVI—11(a). REPORT OF OPINION STUDY OF MSMS

M. L. LICHTER, M.D.: The Reference Committee on Medical Service and Prepayment Insurance submits herewith a partial report of the multitudinous business directed to it.

The Reference Committee has had a tremendous amount of work given to it, and has been hampered somewhat in conducting its meetings due to the pressure of time.

The first item to be presented is in connection with the report of the Survey Committee, which was referred to your Reference Committee.

The remarks of the Speaker and Vice Speaker, the Survey Director and the President-elect were received and approved by the Reference Committee.

In considering this report, the Reference Committee was aware of the great national interest evoked by the survey. Present were representatives from many state medical societies throughout the country; the insurance industry; associations concerned with health services; editors from state medical journals and national medical journals, and members of the press. In addition, numerous requests are being received from a variety of interested organizations.

The Reference Committee was impressed with the extent of the study and the thoroughness with which it was conducted. The Reference Committee strongly urges the utilization of the data of this admirable survey by all those concerned with the subject of prepaid medical care insurance.

Your Reference Committee highly commends the Survey Committee for an assignment well done. Particular commendation is due the Survey Director, Mr. Hugh W. Brenneman, our esteemed Public Relations Counsel, for his unflagging zeal in organizing this monumental effort, his leadership which earned the untiring co-operation of his staff, and his meticulous attention to myriad of detail—and still completing the task on time.

The Reference Committee wishes also to express its highest commendation to those who worked with Mr. Brenneman in this study:

To L. Fernald Foster, M.D., MSMS Secretary, and Mr. William J. Burns, MSMS Executive Director, who with Consultant David J. Luck, Director of the Business Research Institute of Michigan State University and Richard B. Oudersluys, Director of the Market-Opinion Research Company, supported and wisely counseled.

To Warren F. Tryloff, Associate Director of the Study, and Dick Philleo, Supervisor of Production, who at great personal sacrifice devoted their recognized talents unceasingly to the successful execution of the study.

To John B. Kantner of the Michigan Health Council, who so ably wrote, and advised upon the preparation of, the report, as well as the attendant publicity in co-operation with Miss Kay Asby, a devoted and competent special survey assistant.

To Jack Pardee, Miss Jean MacDonald, Miss Vada Studt, Miss Helen Schulte, and the MSMS stenographic staff, who sincerely contributed with their interest and time to the production of the materials upon which the survey depended.

And to Artist Dirk Gringhuis, whose advice and assistance aided the publicity and was responsible for the fine appearance of the report.

Mr. Chairman, I move the adoption of this portion of the report.

C. L. WESTON, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(b). REPORT OF COMMITTEE TO STUDY COMPREHENSIVE PREPAID INSURANCE PLANS

M. L. LICHTER, M.D.: The next item of business considered by the Reference Committee was the report of the Comprehensive Prepaid Medical Care Plan Study Committee, which was ordered by this House at the meeting in September, 1956. I will read the "Resolved" portion of the resolution ordering this Committee:

"RESOLVED: That the Michigan State Medical Society approve exploration with Michigan Medical Service of a comprehensive prepaid deductible and/or co-insurance contract and also the possibility of extension of the present contract; and be it further

"RESOLVED: That the Speaker of this House of Delegates be authorized to appoint forthwith a special committee to accomplish the following:

1. Meet with the representatives of Michigan Medical

Service to study and develop details and mechanisms.

2. Initiate as a joint endeavor, and in co-operation with Michigan Medical Service, necessary studies to ascertain what would best serve the public.

3. Prepare a complete report for presentation to the House of Delegates at its meeting in 1957, with the proviso that copies of this report shall be sent to each member of the House of Delegates by August 15, 1957.

Your Reference Committee directs me as its Chairman to make the following report on the report of this Committee:

We feel that the Committee and its members should be commended for having taken a difficult assignment and carrying it out in a fine manner.

The question is whether I should read the entire report. [*Cries of "Yes."*]

CHAIRMAN LIGHTBODY: This is the report of Dr. Owen's Committee. Did all the delegates receive a copy of the report? I am sure all of you did. Do you wish to have this report read at this time? [*Cries of "No."*]

M. L. LICHTER, M.D.: Your Reference Committee considered the report in its several parts. The first part, which goes nearly to the bottom of page 2, we informally called the Preamble, and we agreed with it in principle and so recommend to this House.

I so move, Mr. Chairman.

J. A. KASPER, M.D.: I support the motion.

CHAIRMAN LIGHTBODY: The motion is to approve the report of Dr. Owen's Committee to the bottom of page 2, ending with the word "recommendation." Is there discussion?

[*The motion was put to a vote and was carried unanimously.*]

[Dr. Lichter read the remaining portion of the report of the Committee to Study Comprehensive Prepaid Insurance Plans, marked No. 1.]

M. L. LICHTER, M.D.: I shall now read the recommendations of the Reference Committee concerning the recommendations of the Study Committee. If I may, Mr. Chairman, I should like permission to read them all, and then take them up one at a time.

CHAIRMAN LIGHTBODY: Proceed.

M. L. LICHTER, M.D.: I am going to read the recommendations of the Reference Committee in their entirety, and the Chair will then decide what will be done with them.

Under the recommendation of the Owen Committee report:

(1) We recommend the adoption of this recommendation.

(2) We offer the following substitution for recommendation No. 2: "That Michigan Medical Service be urged to give consideration to the development of a means whereby the patient of a non-participating physician will be reimbursed by Michigan Medical Service an amount not to exceed the fee called for in the contract fee schedule, unless the patient directs otherwise."

(3) We recommend that this recommendation be changed to the following wording: "That we encourage continued effort to provide broad coverage by Michigan Medical Service for retired people. When welfare and relief agencies desire prepaid medical care coverage for their clients, Michigan Medical Service should stand ready to co-operate."

(4) We recommend that this recommendation be changed to the following wording: "That Michigan Medical Service be urged to give consideration to the inclusion in their contracts of the following additional items:

(a) Office surgery.
(b) Diagnostic x-ray out of the hospital.
(c) Therapeutic x-ray procedures.
(d) Diagnostic laboratory procedures in and out of the hospital.
(e) Physiotherapy in and out of the hospital.
(f) Consultations and surgical assistants.

"And, further, where it would prove necessary to incorporate deductible insurance and/or co-insurance in such contracts, Michigan Medical Service be urged to give consideration to such features."

Recommendation No. 5 in the main was identical with recommendation No. 4, and therefore most of it was incorporated in recommendation No. 4.

(5) We recommend that this recommendation be changed to the following wording: "that the $2,500 and $5,000 contracts be retained."

(6) No action is recommended because we have been informed that The Council is cognizant of the over-all problem of hospital classification and has it under advisement.

(7) and (8) We recommend that these two recommendations be combined with the following wording: "That The Council of the Michigan State Medical Society be urged to develop educational programs covering all phases of prepaid medical care insurance."

(9) We recommend that this recommendation be changed to the following wording: "That the present method of determining income be re-examined."

(10) We recommend that this recommendation be changed to the following wording: "We are opposed to prepayment plans which restrict the subscriber's free choice of a doctor of medicine."

(11) We recommend the adoption of this recommendation.

We have made extensive use of the Opinion Survey in connection with this report, and on nearly all items the Survey contains data. I can go over these recommendations and give the applicable data, or I can do it as you discuss these items.

Mr. Chairman, I move the adoption of this portion of the report of the Reference Committee.

F. D. JOHNSON, M.D. [Genesee]: I support the motion.

R. A. RASMUSSEN, M.D.: On recommendation No. 4 of the Reference Committee there was a rewording in regard to the use of payment for use of consultants and assistants. There has been a considerable amount of discussion about the use of assistants. Many hospitals in our cities have house staffs that may render assistance at times, and there are many hospitals outstate who do not have such house staffs, and they perform certain procedures, surgical primarily, and it may even be necessary to engage the assistance and help of fellow practitioners.

I would suggest that the Reference Committee add the words "when necessary" to this, because otherwise there might be considerable misuse of funds.

M. L. LICHTER, M.D.: It was the feeling of the Reference Committee that this suggestion to Michigan Medical Service would have that sort of limitation as part of the mechanics of developing this particular feature. We were concerned with the principle of obtaining surgical assistance and not defining it any further.

CHAIRMAN LIGHTBODY: Is there a motion to so amend?

R. A. RASMUSSEN, M.D.: I so move.

W. C. BEETS, M.D.: I second the motion.

CHAIRMAN LIGHTBODY: The motion is to amend the report in relation to No. 4(f), and to add the words "when necessary." Is there discussion of the amendment?

W. W. BABCOCK, M.D.: Mr. Chairman, I do not feel that the amendment is necessary, because the Reference Committee specifically requests that Michigan

Medical Service give consideration to these following items. It does not direct them to incorporate.

[*The amendment was put to a vote and was lost.*]

CHAIRMAN LIGHTBODY: The amendment is lost.

A. C. STANDER, M.D.: May I ask for clarification of one point. Did you eliminate in your recommendation 4(d) therapeutic x-ray and radium? I don't recall hearing that read.

M. L. LICHTER, M.D.: No. 4(c), "Therapeutic x-ray procedures." That is in the recommendation.

A. C. STANDER, M.D.: Instead of "Therapeutic x-ray and radium"?

M. L. LICHTER, M.D.: We are told that when one uses the terminology "therapeutic x-ray procedures" it is all-inclusive.

CHAIRMAN LIGHTBODY: The motion is to approve this portion of the report. Is there further discussion?

L. J. BAILEY, M.D.: Are we approving all eleven recommendations in the Owen report as amended?

CHAIRMAN LIGHTBODY: Yes, as amended.

L. J. BAILEY, M.D.: When the Chairman of the Reference Committee said he was going to read all these recommendations, he said he would read them all and then take them up one at a time.

I move you that they be taken up one by one.

R. W. TEED, M.D.: Is there not a valid motion on the floor?

CHAIRMAN LIGHTBODY: There is a motion for adoption of this portion of the report up to now. With the permission of the maker of that motion, who is the Chairman of the Reference Committee, we might proceed to discuss each item separately.

M. L. LICHTER, M.D.: Mr. Chairman, I withdraw my motion to approve this portion of the report.

CHAIRMAN LIGHTBODY: With the consent of the seconder we will remove that motion from the floor. Thank you.

There is a motion to discuss each one of these recommendations separately. It has been seconded by several. Are you ready to vote?

[*The motion was put to a vote and was lost.*]

CHAIRMAN LIGHTBODY: The motion is lost.

F. D. JOHNSON, M.D.: Mr. Chairman, I did not remove my second to the original motion.

M. L. LICHTER, M.D.: Mr. Chairman, I move the adoption of this portion of the report.

[*The motion was severally seconded.*]

CHAIRMAN LIGHTBODY: It is moved and seconded that this portion of the report be approved, that is, the recommendations of the Reference Committee as amended up to this point. That is the motion before you. Is there further discussion?

[*The motion was put to a vote and was carried.*]

XVI—11(c). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION RE RECOGNITION OF PATHOLOGY UNDER MEDICARE

M. L. LICHTER, M.D.: Your Reference Committee had two resolutions (among many submitted to it) on which it is prepared to report, namely, resolutions Nos. 25 and 26. They deal with the same general topic, yet they cannot be combined.

The Reference Committee has taken the motions as submitted and has amended them, not in substance but for clarification. May I read the clarified version of these motions and save the time of the House in reading the same thing over again.

I have been instructed to read the "Resolved" portions of the original resolutions. I believe it might be best to read them *in toto*.

[*Dr. Lichter read resolutions Nos. 25 and 26.*]

M. L. LICHTER, M.D.: Now, Mr. Chairman, with your permission I should like to read the amended version of resolution No. 25:

"Whereas, the American Medical Association and the Michigan State Medical Society have declared that the practice of pathology is the practice of medicine, and

"Whereas, pathologic services may be rendered in or outside of a hospital, and

"Whereas, such pathological services can be performed only by or under the supervision of qualified physicians, and

"Whereas, the Michigan Medical Service has contracted for the Michigan State Medical Society and for the physicians of Michigan with the Department of Defense to supply medical services to dependents of the uniformed forces under public Law No. 569 of the 84th Congress (otherwise known as the Dependent's Medical Care Act, or 'Medicare'), and

"Whereas, certification of medical services rendered can be made only by physicians; be it therefore

"RESOLVED: That in all future 'Medicare' contract negotiations recognition be made of the principle that pathology is a medical service and that every reasonable effort be made to have fees for such services paid to the physicians rendering the services."

Mr. Chairman, I move the adoption of this resolution as amended.

J. A. KASPER, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(d). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION RE RECOGNITION OF PATHOLOGY IN BLUE CROSS-BLUE SHIELD

M. L. LICHTER, M.D.: Now may I read the "Resolved" portion of original resolution No. 26.

[*Dr. Lichter read the "Resolved" portion of resolution No. 26.*]

The amended resolution is as follows:

"Whereas, the American Medical Association and the Michigan State Medical Society have declared that the practice of pathologic anatomy and clinical pathology is the practice of medicine, and

"Whereas, pathologic services whether rendered to inpatients or outpatients are medical services, and

"Whereas, such pathologic services can be performed only by or under the supervision of qualified physicians, and

"Whereas, the Michigan Medical Service has contracted for the Michigan State Medical Society and for the physicians of Michigan to supply medical services to subscribers, and

"Whereas, certification of medical services rendered can be made only by physicians; be it therefore

"RESOLVED: That the Michigan State Medical Society hereby declares that pathology is a medical service, and that coverage for such services should be included in the Michigan Medical Service contracts rather than in the Michigan Hospital Service contracts, and that fees for such services should be paid to the physicians rendering the services; and be it further

"RESOLVED: That a copy of this resolution be forwarded to the corporate body of the Michigan Medical Service and its Board of Directors."

Mr. Chairman, I move the adoption of this resolution as amended.

R. W. TEED, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

THE SPEAKER: There are two reports to be called for at this time. Dr. Sellers, do you have a supplemental report of the Reference Committee on Officers' Reports?

XVI—14(f). WOMAN'S AUXILIARY SPONSORSHIP OF FREEDOM ESSAY CONTEST

CHARLES SELLERS, M.D.: The Reference Commit-

tee on Officers' Reports had one short resolution referred to it, submitted by R. F. Fenton, M.D.

[*Dr. Sellers read the "Resolved" portion of resolution No. 32.*]

The Reference Committee approves the suggestion of the Woman's Auxiliary to the Michigan State Medical Society, and encourages its component societies to promote the American Association of Physicians and Surgeons Freedom Essay Contest among high school students as one of their projects.

Mr. Speaker, I move that this portion of the report be accepted.

HUGH W. HENDERSON, M.D. [Wayne]: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The meeting adjourned at 5:30 p.m.*]

TUESDAY EVENING SESSION
September 24, 1957

The meeting reconvened at 8:30 p.m., K. H. Johnson, M.D., Speaker of the House of Delegates, presiding.

THE SPEAKER: It is customary at the last session of the House of Delegates to introduce the Past Presidents who may be present. I shall call their names, and if they are here I shall appreciate their coming down to the front.

W. S. Jones, M.D., Menominee.
L. Fernald Foster, M.D., Bay City.
L. W. Hull, M.D., Detroit.
R. J. Hubbell, M.D., Kalamazoo.
R. L. Novy, M.D., Detroit.
Otto O. Beck, M.D., Birmingham.
C. E. Umphrey, M.D., Detroit.
Wilfrid Haughey, M.D., Battle Creek.
E. F. Sladek, M.D., Traverse City.
William A. Hyland, M.D., Grand Rapids.
Henry R. Carstens, M.D., Detroit.
J. Milton Robb, M.D., Detroit.
Grover C. Penberthy, M.D., Detroit.
Burton R. Corbus, M.D., Grand Rapids.
Paul R. Urmston, M.D., Bay City.

We are very happy to have you gentlemen with us. It is always a distinct honor and privilege for the Speaker to introduce you gentlemen to the House of Delegates.

O. K. ENGELKE, M.D.: Mr. Speaker, I move that the usual order of business be suspended, that at this time we proceed with item 30 on the agenda, the election of officers, and that following the election we entertain the report of the Reference Committee.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

XVII. ELECTIONS

THE SPEAKER: We shall proceed.

The first item under elections will be the nomination of Councilor for the Seventh District. H. B. Zemmer, M.D., of Lapeer, is the present incumbent. Do I hear nominations?

C. W. OAKES, M.D.: May we defer this item for a moment? The man who was to make a nominating speech is not here. May we come back to it?

THE SPEAKER: Very well.

XVII—1. COUNCILOR FOR THE EIGHTH DISTRICT

Councilor for the Eighth District: L. C. Harvie, M.D., of Saginaw, is the incumbent. Nominations are open for Councilor from the Eighth District.

H. L. GORDON, M.D. [Midland]: On behalf of Tuscola County, Saginaw, Gratiot, Isabella, Clare and Midland, I would like to propose the name of E. S. Oldham, M.D. He is an old friend, well known in all of these counties. He is in an excellent position to represent these component societies, and I think he will add a spark that those societies would like to see in The Council.

I nominate Dr. E. S. Oldham, of Breckenridge, as Councilor of the Eighth District.

J. P. MARKEY, M.D. [Saginaw]: I second the nomination.

THE SPEAKER: Are there further nominations? What is your pleasure?

O. K. ENGELKE, M.D.: I move that nominations be closed and that a unanimous ballot be cast for Dr. Oldham.

THE SPEAKER: I believe the Chair will rule that inasmuch as there is no other nominee, and as there is a quorum present in this room, it will be perfectly in order if we vote on this nominee as presented.

All those in favor, say "aye"; opposed, "no." Dr. Oldham is elected. [*Applause*]

XVII—2. COUNCILOR FOR THE NINTH DISTRICT

Councilor for the Ninth District: G. B. Saltonstall, M.D., Charlevoix, is the incumbent.

R. V. DAUGHERTY, M.D. [Wexford-Missauke]: I would like to nominate G. B. Saltonstall as Councilor for the Ninth District.

THE SPEAKER: Dr. Saltonstall has been nominated as Councilor for the Ninth District. Are there further nominations?

H. C. HANSEN, M.D. [Calhoun]: I move that nominations cease and that the Secretary cast the unanimous ballot.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

THE SPEAKER: Dr. Saltonstall has been elected.

XVII—3. COUNCILOR FOR THE TENTH DISTRICT

Tenth District: W. S. Stinson, M.D., Bay City, is the incumbent. Are there nominations for Councilor for the Tenth District?

D. A. BOWMAN, M.D. [Bay-Arenac-Iosco]: I am speaking for the Tenth District and the counties involved. I would like to place in nomination the name of O. J. Johnson, M.D., as Councilor for the Tenth District.

F. D. JOHNSON, M.D.: I second the nomination of Dr. Johnson.

I move that nominations be closed and that a unanimous ballot be cast for Dr. Johnson.

[*The motion was severally seconded.*]

D. A. BOWMAN, M.D.: May I make a statement in explanation of why Dr. Stinson was not renominated? Dr. Stinson is ill. He has plasma cell myeloma and is in the hospital.

THE SPEAKER: Thank you very much, Dr. Bowman.

[*The motion was put to a vote and was carried unanimously.*]

XVII—4. COUNCILOR FOR THE SEVENTH DISTRICT

THE SPEAKER: Is the Seventh District now ready?

K. T. MCGUNEGLE, M.D.: Due to circumstances which will probably come up later on in the evening, Dr. Zemmer does not wish to run again for the office of Councilor.

We have an excellent man in our District whom all of you know. His qualifications are known because they were printed in the yellow book we received this afternoon. I would like to nominate J. F. Beer, M.D., of St. Clair, as Councilor for the Seventh District.

F. P. RHOADES, M.D.: I second the nomination.

C. W. OAKES, M.D.: I second that nomination also, and move that nominations be closed and that the Secretary cast a unanimous ballot for Dr. Beer.

O. K. ENGELKE, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVII—5. DELEGATES TO AMA

THE SPEAKER: We have three delegates to the AMA to be elected. The present incumbents are Dr. W. A. Hyland, of Grand Rapids; Dr. J. S. DeTar, of Milan, and Dr. C. I. Owen of Detroit. Nominations are now in order for delegates to the AMA.

W. C. BEETS, M.D.: We in Kent County over a period of many years have learned to admire and respect Dr. William A. Hyland. We think he is doing a very valuable job as delegate to the AMA, and we would like to nominate Dr. Hyland to succeed himself.

R. V. WALKER, M.D.: I endorse the nomination and second it. Dr. Hyland is one of our most valuable representatives in the Michigan State Medical Society. I very highly endorse him for this office.

O. K. ENGELKE, M.D.: I would like to place in nomination, to succeed himself, the name of a gentleman who needs no introduction to this group, one who has been active in his medical society for many years and who is still very active.

He was a member of this House for many years, and eventually served as Speaker of this House. He is a member of The Council of the Michigan State Medical Society. He has been ambassador for American medicine as we know it for many years across the length and breadth of this country. I speak of Dr. J. S. DeTar, of Milan.

R. W. TEED, M.D.: On behalf of the Washtenaw County delegation I second the nomination of Dr. DeTar.

THE SPEAKER: Are there any further nominations?

M. A. DARLING, M.D.: I believe it is customary, when a man has served efficiently and tirelessly in a position both as alternate delegate and then as delegate to the American Medical Association, that he be returned to that position.

I take pleasure, on behalf of the Wayne County delegation, in presenting the name of Dr. Clarence I. Owen, of Detroit.

C. K. HASLEY, M.D. [Wayne]: I support the nomination of Clarence Owen as delegate to the AMA.

R. F. FENTON, M.D.: I move that nominations be closed and that the three nominees be declared elected unanimously.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

THE SPEAKER: Dr. Hyland, Dr. DeTar and Dr. Owen have been re-elected unanimously as delegates to the AMA. [*Applause*]

XVII—6. ALTERNATE DELEGATES TO AMA

THE SPEAKER: We come now to the election of three alternate delegates to the AMA. Nominations are now in order.

LOUIS JAFFE, M.D. [Wayne]: On behalf of the Wayne delegation I would like to place in nomination as alternate delegate the name of Dr. Warren W. Babcock, who, as you know, has filled the position for the last several years with distinction. He has earned the respect of his colleagues. Dr. Babcock is a Past President of his County Society and a Trustee, and I am sure his activities both here and on the national level are known to all of you. I know of no one more qualified to carry forward the principles of this Society on the national level than Dr. Warren W. Babcock.

E. F. LUTZ, M.D. [Wayne]: I second the nomination and draw your attention to his efficient work here, which will carry over to the floor of the House of Delegates of the AMA.

R. R. GARNEAU, M.D. [Manistee]: I would like to place in nomination the name of a man who is a Past President, to succeed himself, who has been a tireless worker and a very competent man. Dr. Ed Sladek, of Traverse City.

J. F. BEER, M.D. [St Clair]: I would like to place in nomination the name of a man who has served as alternate delegate and has done a good job. He has been elected Councilor this evening. I would like to nominate Dr. O. J. Johnson, of Bay County.

W. L. BROSIUS, M.D.: I would like to place in nomination the name of a man who is already well known to this House. His name was before the delegates this afternoon in a special resolution. He is Past President of the Wayne County Association and has worked tirelessly. He is well known not only throughout the State but nationally. I nominate Dr. Luther R. Leader.

H. B. FENECH, M.D. [Wayne]: I second the nomination of Dr. Leader.

G. H. BAUER, M.D.: I move that nominations cease.

O. K. ENGELKE, M.D.: I support the nomination.

[*The motion was put to a vote and was carried unanimously.*]

THE SPEAKER: We have four nominees for alternate delegate to the AMA. There are only three vacancies. If you will use ballot No. 2 in your Handbook, we will ask you to vote.

The tellers, Drs. R. F. Fenton, Strom, Rasmussen and Bielawski will collect the ballots.

[*Voting.*]

THE SPEAKER: The order of sequence concerning the alternate delegates is determined by the number of votes received by each nominee. The highest number of votes designates the No. 1 alternate, the second No. 2, and the third No. 3.

THE SPEAKER: The report of the tellers for alternate delegates is: Dr. Babcock, Dr. Sladek and Dr. Johnson, in that order. This means that these men become Nos. 4, 5 and 6. If you don't know what that means, it means that we already have Nos. 1, 2 and 3. The alternate delegates are elected for a term of two years, so we elect three alternates each year, and the men who were Nos. 4, 5 and 6 last year become Nos. 1, 2 and 3. Next year the ones who are Nos. 4, 5 and 6 this year become Nos. 1, 2 and 3 next year. I hope it is as clear to you as it is to me.

XVII—7. PRESIDENT-ELECT

Nominations are now in order for the office of President-elect.

CHARLES SELLERS, M.D.: I wish to place in nomination for the office of President-elect the name of Dr. Harry B. Zemmer, of Lapeer.

Permit me to say that Dr. Zemmer was born at Columbiaville, Michigan, in 1895. He graduated from Wayne State University College of Medicine in 1920. He has been a member of the Michigan State Medical Society since 1920.

Dr. Zemmer started practice in Mayville, but soon moved to Lapeer, where he has remained continuously since 1924 engaged in general surgery and some general practice.

He is a former delegate from Lapeer County to this House of Delegates. He is a former President of the Lapeer County Medical Society, having filled that office several times. He is a former Chairman of the State Mental Health Commission and President of the Michigan Health Council, and was Chairman of Michigan's first Rural Health Conference at Lansing.

Dr. Zemmer is a member and has been Vice Chairman of The Council of the Michigan State Medical Society, where he has served faithfully according to the testimony of other Councilors.

Participation in civic responsibilities is an important duty of practicing physicians, and Dr. Zemmer has been very active. He is a Director and former President of the Lapeer State Savings Bank during the past thirty years. He is a member and former President of the Lapeer Chamber of Commerce, a member of the School Board, a former President of the Rotary Club, and a member of the Farm Bureau. Dr. Zemmer owns a 360-acre farm located about ten miles from Lapeer, where he now lives.

Just a personal note: I have known Dr. Harry B. Zemmer since medical college days, which covers more years than either of us care to admit. I recommend him into the members of the House of Delegates as a physician and a gentleman who would be a capable President-elect and, in due time, be a credit to us as President of the Michigan State Medical Society.

A. B. GWINN, M.D. [Barry]: I second the nomination of Harry Zemmer for President-elect of this Society.

C. I. OWEN, M.D.: It is a great pleasure for me to second the nomination of Dr. Zemmer, a classmate of mine.

C. W. OAKES, M.D.: I take great pleasure in seconding the nomination of Dr. Zemmer for President-elect.

THE SPEAKER: Are there further nominations?

J. R. RODGER, M.D.: The man whom I am going to place in nomination has been a member of this House of Delegates. He has been a member of The Council of the Michigan State Medical Society for seven years, five of those seven having been spent on the Executive Committee of The Council. If he were elected to this position he would, of course, resign as a member of The Council.

I am very happy to place in nomination my friend and the friend of all of us in this room, Dr. G. B. Saltonstall of Charlevoix.

D. G. PIKE, M.D. [Grand-Traverse-Leelanau-Benzie]: I would like to have the honor of seconding the nomination of Gilbert Saltonstall for the office of President-elect.

O. J. JOHNSON, M.D.: I support the nomination of Dr. Saltonstall.

F. L. TROOST, M.D.: I also second the nomination of Dr. Saltonstall.

THE SPEAKER: Are there further nominations?

R. W. TEED, M.D.: I move that nominations be closed.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

THE SPEAKER: Will you use ballot No. 3 in your Handbook? Will the tellers please collect the ballots and proceed to count them and then report?

[*Voting.*]

THE SPEAKER: The Speaker announces the election of Dr. Saltonstall as President-elect. Will someone conduct Dr. Saltonstall to the rostrum?

G. B. SALTONSTALL, M.D. [Charlexoix]: I am a little overwhelmed and very humble in accepting this signal honor that you have awarded me. I am sure I shall need all of your help in carrying on the duties of this office, and I assure you that I shall serve you all to the very best of my ability.

XVII—2. COUNCILOR FOR THE NINTH DISTRICT

THE SPEAKER: I am not quite sure of the procedure. Dr. Saltonstall, do you wish to resign as Councilor, or shall I declare your office vacant? I wonder if the the Ninth District wishes to have a caucus or is prepared to present another nomination for Councilor of the Ninth District.

J. R. RODGER, M.D.: I should like to present the name of a man who has been a member of this House for eight years, and a member of many important reference committees of this House, whom we in the Ninth District would be very proud to have represent us. I nominate Dr. Donald Pike, of Traverse City.

K. T. MCGUNEGLE, M.D.: I support the nomination of Dr. Pike.

THE SPEAKER: Are there further nominations?

R. R. GARNEAU, M.D.: I move that nominations be closed and that the Secretary cast the unanimous ballot for Dr. Pike.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

THE SPEAKER: Dr. Pike is declared elected.

Nominations are now in order for Speaker of the House of Delegates.

XVII—8. SPEAKER OF THE HOUSE OF DELEGATES

[*The Vice Speaker assumed the Chair.*]

L. A. DROLETT, M.D.: Gentlemen, I think this young fellow has done a pretty good job up here for a year [*applause*], and I think he well deserves to be returned to office. He has done a marvelous job in conducting the business of this House of Delegates, and once again I would like to nominate Dr. Kenneth H. Johnson to succeed himself as Speaker of the House.

J. M. WELLMAN, M.D.: I second the nomination of Dr. Johnson as Speaker. He is a very close personal friend of mine, and a moderately good poker player. [*Laughter*]

J. E. LIVESAY, M.D.: I second the nomination of Dr. Johnson, and at the same time move that nominations be closed and that the Secretary cast the unanimous ballot for Dr. Johnson.

W. L. BROSIUS, M.D.: I second that motion.

[*The motion was put to a vote and was carried unanimously.*]

[*The Speaker resumed the Chair.*]

XVII—9. VICE SPEAKER OF THE HOUSE OF DELEGATES

THE SPEAKER: Nominations are now in order for Vice Speaker of the House of Delegates.

J. B. BLODGETT, M.D.: On behalf of the Wayne delegation I should like to nominate as Vice Speaker of the House of Delegates the capable incumbent, J. J. Lightbody.

E. H. FENTON, M.D.: It gives me extreme pleasure to second the name of Dr. Lightbody. He has done a fine job this year, and I am sure we are all very pleased. [*Applause*]

W. S. JONES, M.D.: I move that nominations be closed and that Dr. Lightbody be re-elected Vice Speaker and Parliamentarian by acclamation. [*Applause*]

THE SPEAKER: That acclamation will record the vote as a complete "Yes." Congratulations, Dr. Lightbody.

I would simply like to say that I appreciate very much all the kind words that have been said to me. It is very obvious that no Speaker can possibly do a good job without a great deal of help, and I certainly feel I have had it during this session.

I know Jim has done an excellent job in helping me and everyone else. Jim, would you like to say something?

THE VICE SPEAKER: It has been an interesting experience for me. I have had a little experience before, but this has been sort of a rough initiation. The delegates have been very kind to both Dr. Johnson and myself at this session. We haven't run into a great

number of parliamentary difficulties, but of course the evening is not over.

I want to thank you very much for this honor, and I hope we shall continue to be friends. Thank you.

THE SPEAKER: We shall now return to the regular order of business. The last information I had from Dr. Lichter was that he would not be ready before eleven o'clock tonight.

R. W. TEED, M.D.: I move that we adjourn until eight o'clock tomorrow morning.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

[*The meeting was adjourned at 10:15 p.m.*]

WEDNESDAY MORNING SESSION
September 25, 1957

The final session convened at 8:40 a.m., K. H. Johnson, M.D., Speaker of the House of Delegates, presiding.

M. L. LICHTER, M.D.: At this time I should like to thank those members of the House who assisted the Reference Committee in its deliberations and in enabling it to arrive at a conclusion which the Reference Committee feels represents the thinking of this House. Everyone was kind to us, patient with us, and most helpful.

As Chairman of this Reference Committee, I must pay the highest tribute to the members of the subcommittee, who gave up just about everything in order to assist in this task which is to be presented to you this morning.

I would like to say that all matters to be presented this morning by this Reference Committee have the unanimous consent and agreement of the members of that Committee: Laurence S. Fallis, M.D., H. C. Hill, M.D., R. L. Novy, M.D., D. G. Pike, M.D., Sydney Scher, M.D., and W. F. Strong, M.D.

It has been a great personal pleasure to have worked with these men, and I can't express myself too strongly and sincerely in that regard.

We have a number of resolutions that we would like to present to the House before the presentation of the report of the Reference Committee on Michigan Medical Service, which resolutions were sent to us as a supplemental report of The Council.

XVI—11(e). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION: RECOGNITION OF INTERNISTS

[*Dr. Lichter read resolution No. 23.*]

"Whereas, this House of Delegates, as representatives of the medical profession in Michigan, is dedicated to promote higher standards of medical service, and

"Whereas, the maintenance of high standards of medical care often includes the services of the internist, and

"Whereas, this House of Delegates is anxious to maintain unity of the medical profession in Michigan in order to further favorable solution of the economic problems of medical care; therefore, be it

"RESOLVED: That the House of Delegates recognizes the internist as a medical specialist whose special training, skills and detailed investigation and service rendered the patient entitles him to compensation commensurate with such service both as an attending physician or consultant."

M. L. LICHTER, M.D.: We believe that ample opportunity was given all the proponents of this resolution to be heard.

The Reference Committee makes the following recommendation: To the knowledge of the Reference Committee, there is no established official policy regarding special recognition of any specialty group. Therefore, it is recommended that this resolution be **disapproved.**

Mr. Speaker, I move the adoption of this recommendation.

J. M. WELLMAN, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(f). RE FREE CHOICE OF PHYSICIAN IN ALL MEDICAL SERVICE PLANS

[*Dr. Lichter read resolution No. 4.*]

M. L. LICHTER, M.D. [continuing]: This resolution was carefully considered by the Reference Committee, and they make the following recommendation: The Reference Committee recommends no action on this resolution at this time.

Mr. Speaker, I move the adoption of this recommendation.

R. W. TEED, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(g). RE MERGER OF BLUE SHIELD-BLUE CROSS

[*Dr. Lichter read resolution No. 10.*]

M. L. LICHTER, M.D. [*continuing*]: The Reference Committee recommends **disapproval** of this resolution, and I so move.

J. B. BLODGETT, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(h). RE SEPARATION OF BLUE CROSS-BLUE SHIELD

M. L. LICHTER, M.D.: Now to the next resolution. After careful consideration of this resolution, the Reference Committee recommends its **disapproval**, and I so move.

V. M. ZERBI, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(i). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION: RE TO CHANGE MHS-MMS INTO INDEMNITY PLANS

[*Dr. Lichter read resolution No. 24.*]

"RESOLVED: That the Calhoun County Medical Society hereby requests the Michigan State Medical Society to give consideration to the employment of its influence and good offices to effect some or all of the following changes in Michigan Hospital Service-Michigan Medical Service:

"1. Discontinuance of the 'service' concept.
2. Adoption of a deductible hospitalization plan.
3. Adoption of an indemnity fee schedule for physicians' services.
4. Adoption of an indemnity fee schedule for outpatient or office diagnostic x-ray examinations.
5. Payment of surgical indemnity fees regardless of where the surgery is performed."

M. L. LICHTER, M.D. [*continuing*]: The recommendation of the Reference Committee is: This resolution is disapproved because it is at variance with the report of the Committee to Study Comprehensive Prepaid Insurance Plans and the Opinion Survey, and our recommendation concerning the report of the Committee on Michigan Medical Service.

I move adoption of the recommendation to **disapprove.**

W. C. BEETS, M.D.: Second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(m). COMPREHENSIVE MEDICAL SERVICE PLAN

[*Dr. Lichter read resolution No. 21.*]

M. L. LICHTER, M.D.: The Reference Committee recommends *no action* on this resolution, because most

of the resolution was covered by the report of the Committee to Study Comprehensive Prepaid Insurance Plans.

I so move, Mr. Speaker.

R. W. TEED, M.D.: Support.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(j). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION: LIMIT BS CONTRACTS TO THOSE WITH SPECIFIED INCOME LIMITS

[*Dr. Lichter read resolution No. 20.*]

"Whereas, considerable confusion exists in the minds of the public in regard to income limits of their policies, and

"Whereas, fee schedules as set up in specific contracts tend to be accepted by the patient as usual fees for the various procedures, and

"Whereas, poor public relations may result when fees in excess of their Blue Shield contracts are charged; therefore, be it

"RESOLVED: That the Board of Directors of Michigan Medical Service be encouraged to initiate a plan as rapidly as possible by which Blue Shield contracts are limited to those individuals whose family income falls within the income limits of their policies; and be it further

"RESOLVED: That the corporate body of Michigan Medical Service go on record as favoring the discontinuance of the present $2,500 policy, and a new contract for all incomes above $5,000 be formulated."

M. L. LICHTER, M.D. [*continuing*]: The Reference Committee recommends that this resolution be disapproved because it is at variance with the report of the Committee on Michigan Medical Service, and at marked variance with the result of the Opinion Survey on this topic.

I move acceptance of this recommendation to **disapprove.**

A. C. STANDER, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—11(k). FROM APRIL, 1957, HOUSE OF DELEGATES SESSION: RE INCREASED BENEFITS IN MMS CONTRACTS

[*Dr. Lichter read resolution No. 27.*]

"Whereas, the Committee on Prepaid Medical Care Plans of the Wayne County Medical Society has studied extensively the various methods of prepaid medical care available in the United States, and

"Whereas, it is the opinion of the Committee that a medical society may logically sponsor only a service type plan, and

"Whereas, the Committee has concluded that the general public desires wider benefits in a prepaid plan than are now available in Michigan Medical Service, and

"Whereas, an essential feature in such a plan should be a mutual sense of responsibility on the part of the physician and on the part of the patient, and

"Whereas, the traditional right of the patient to choose his own physician must be preserved; therefore, be it

"RESOLVED: That Michigan Medical Service be respectfully requested after a thorough study of actuarial factors to devise a contract providing increased benefits patterned on the General Electric Plan; and be it further

"RESOLVED: That this contract embody extensive diagnostic and therapeutic benefits to the subscriber in the hospital, office and home; provide for both an initial deductible feature and a co-insurance plan for more extended and expensive illness; and pay the physician without a fixed schedule his usual fee for a given service; and be it further

"RESOLVED: That this House of Delegates favors continuation of policies now being offered by Michigan Medical Service."

M. L. LICHTER, *M.D.* [*continuing*]: Your Reference Committee recommends that this resolution be *referred to the Board of Directors of Michigan Medical Service* for its consideration and utilization of such features of the resolution as may be desirable.

I so move, Mr. Speaker.

F. P. RHOADES, M.D.: I second the motion.

[*The motion was put to a vote and was carried unanimously.*]

XVI—10(a). REPORTS OF THE COUNCIL (CONTINUED)

M. L. LICHTER, M.D.: This is the report of the Council on which your Reference Committee spent many, many hours. Most of the members of the Committee have had between thirty minutes and one hour's sleep last night.

The report of the Committee on Michigan Medical Service, which is part of the supplemental report of The Council, is divided into four parts. The four parts are the general considerations; commitments by the Michigan State Medical Society; principles to be embodied in insurance contracts, and basis of service benefits.

As this report is presented I believe it should be kept firmly in mind that this is a basic set of principles. There may be detailed points absent, but the framework of the development of the detail is definitely present in the report.

The report was amended in some respects by the Reference Committee. I am not going to read the report as it was submitted to us by the Speaker, but I am going to read the report as it has been amended by the Reference Committee. I will be prepared, if it is considered necessary, to point out the various areas in which amendments were made.

A. GENERAL CONSIDERATIONS

The Michigan State Medical Society has made an intensive study of the development and the operation of the many means currently employed both in Michigan and elsewhere to insure against or to prepay the costs of medical care. The conclusions resulting from that study are set forth below and are based upon the following fundamental considerations:

1. The people of Michigan are entitled to and should have health care which meets the highest standards attainable.

2. Means should be generally available in Michigan which will permit the financing of the costs of necessary medical services and supplies to the greatest extent possible and practicable through prepayment.

3. To whatever extent the cost of a particular medical service is not covered by prepayment, such uncovered amount shall be predictable, be known to the patient in advance, and be within his ability to budget for out of income.

The foregoing can be accomplished only if those responsible for rendering the necessary medical services, namely, the physicians of Michigan, assume the further responsibility of establishing within the profession a structure around which sound insurance or prepayment plans can be built and also a system by which the profession can assure itself, the prepayment plan subscribers and the underwriters, that the structure is functioning in accordance with its commitments.

B. COMMITMENTS BY THE MICHIGAN STATE MEDICAL SOCIETY

In light of the foregoing, the Michigan State Medical Society undertakes the following commitments:

1. Any contract offered by an insurance carrier or prepayment plan organization which embodies the principles set forth in Section C herein shall receive the endorsement of the Society, provided the carrier issuing this contract shall stipulate it will not offer any pre-

paid medical care contract which is preferential or discriminatory in its rating. This endorsement shall remain in effect as long as the carrier continues to make such contracts available and keeps the stipulation in effect.

2. It being the objective of the medical profession to make certain that voluntary health protection be available to all self-sustaining people at reasonable cost, the endorsement of the Michigan State Medical Society will be given only if rates charged by the insurance or prepayment carrier are fair and equitable and nondiscriminatory.

3. The Society will use its best efforts to secure the participation of its members in all contracts endorsed by the Society.

4. A subscriber rendered care by a participating physician will receive "service benefits" as provided in his contract. The basis is set forth in Section D below.

5. The Council of the Michigan State Medical Society will appoint a Medical Care Insurance Committee having the following functions:

(a) To examine all contracts submitted for endorsement. A report will be sent to The Council which will have the authority to issue a certificate of endorsement on behalf of the Society.

(b) To co-operate with the Permanent Advisory Committee on Fees of the House of Delegates concerning the Relative Value Scale and applicable unit values.

(c) To develop review procedures for any matters concerning the subscriber, the physician, the insurance carrier and others.

(d) To develop review committees in each of the Councilor Districts of the Society, nominated locally, which shall be appointed by The Council of the Michigan State Medical Society. These shall function under the direction of the Medical Care Insurance Committee, which will also serve as a unit to which appeal can be made from decisions of the review committee(s).

(e) To make such interpretations of the language herein as may be required in connection with the endorsement of contracts.

6. Amendments to or interpretations of the language herein as may be made by The Council of the Michigan State Medical Society during the interim between meetings of the House of Delegates of the Michigan State Medical Society.

7. The Michigan State Medical Society, sponsor of Michigan Medical Service, will urge Michigan Medical Service to make available to any qualified group or individual protection in accordance with the principles herein set forth at fair and equitable rates, and pledges its support in such an endeavor.

C. PRINCIPLES TO BE EMBODIED IN INSURANCE CONTRACTS

1. There must be complete freedom of choice of physician by the patient. Nothing in any contract will imply any restriction of this principle.

2. All benefits will be on a service basis consistent with the principles set forth in Section D, except when a subscriber voluntarily occupies a private room in a hospital.

3. The following services must be included in any basic program:

(a) Surgical procedures wherever performed.

(b) Medical services when the patient is confined to a hospital.

(c) Consultation service in the hospital; surgical assistants where required.

(d) Obstetrical services for the actual procedure in normal delivery, Caesarean section or abortion and complications of pregnancy, but not to include routine prenatal and post-natal care. Optional supplemental insurance by the carrier to cover all obstetrical costs may be offered as provided in No. 4 below.

(e) Anesthesia by a physician not an employe of a hospital.

(f) Diagnostic laboratory procedures shall be provided in the outpatient department of a hospital, a private laboratory, in the physician's office. (Screening procedures are excluded.)

(g) Diagnostic and therapeutic radiologic procedures shall be provided in the hospital, the outpatient department, or in the physician's office.

4. At the option of the carrier, additional coverage may be provided for other medical services and supplies such as:

(a) Home and office calls.

(b) Benefits for prescriptions filled by a registered pharmacist.

(c) The furnishing of prosthetic devices.

(d) Physiotherapy in the outpatient department or the physician's office.

(e) Other services which may be required in the treatment of the patient.

5.(a) For any necessary service other than in-hospital medical care, surgical care, obstetrical care and anesthesia, the subscriber shall have, at the time of utilization, a degree of financial participation in, and responsibility for, medical fees in addition to his premium. This shall be determined by the carrier, but the responsibility of the patient shall be not less than 10 per cent or $5, whichever is more, but not in excess of the scheduled fee allowance. In accordance with the terms of the contract, this amount shall become the obligation of the patient to the physician at the time of service and will be subtracted by the carrier from the payment for service it shall make to the physician. For any calendar year, however, patient participation shall not exceed the following:

Contract for Which Eligible	*Limit of Patient Participation Per Year*
A	$25
B	50
C	75

(b) While the provisions of "a" above are strongly urged by the Michigan State Medical Society, any carrier may have the option to waive the provision of "a" by a rider to provide for coverage without subscriber contribution.

6. There shall be three contracts to be known as plans A, B, C. Each of these contracts shall apply to a specific income level and will provide service benefits. The income level shall be determined by a projection of the current rate of earnings of the basic wage earner in the family and not by family income.

Where the basic income is not readily determined and established (such as self-employed, farmers, salesmen on commission) the Committee on Medical Care Insurance of the Michigan State Medical Society shall develop appropriate criteria for determining eligibility for service benefits.

Plan A will provide full service benefits to all subscribers whose basic income is less than $2,500.

Plan B will provide full service benefits for those subscribers whose basic income is $2,500 but less than $5,000.

Plan C will provide full service benefits for those subscribers whose basic income is $5,000 but less than $7,500.

Those subscribers whose income is in excess of $7,500 may purchase only *Plan C*. In this event the total fee shall be the result of agreement between the patient and his physician. The Plan will pay the applicable and "Dollar Allowance" to the physician.

7. The insurance carrier shall be responsible for classification of subscribers and appropriate designation of the Plan in which they must be enrolled. Income designation shall reflect the subscriber's current rate of pay, projected on an annual basis. This designation shall be reviewed annually and changed as indicated by the review.

D. BASIS OF SERVICE BENEFITS

1. The Michigan State Medical Society will develop a "Relative Value Scale" which will assign to the individual surgical, obstetrical and other medical services a value in units proportional to the relative value of that service. The Society will determine the applicable value of one unit for each class of benefit. By multiplying the number of units assigned to a procedure by the value of one unit, the "Dollar Allowance" for that procedure is obtained.

2.(a) The Michigan State Medical Society will establish unit values for medical, surgical and obstetrical procedures and anesthesia for each of the Plans.

(b) For diagnostic laboratory procedures and for all radiologic procedures, the unit value will be the same for all Plans.

(c) For any optional benefits offered by a carrier, the Society will establish appropriate unit values.

3. Until the Michigan State Medical Society establishes a "Relative Value Scale," the scale developed by the California Medical Association shall be used.

4. No participating physician may charge more for a particular service rendered a subscriber than the "Dollar Allowance" payable for that service under the subscriber's contract. A subscriber covered by Plan C, whose income is designated as in excess of $7,500, however, shall be responsible for any part of fees to which he agrees with his physician in excess of the applicable "Dollar Allowance."

Mr. Speaker, I have an explanatory note which is not part of this report, which I would like to present and perhaps interpolate at this moment.

The Reference Committee discussed and considered the possible inclusion of coverage for in-hospital diagnostic laboratory procedures under Section C, paragraph 3(F). It was agreed that when the method of payment to the pathologist for services rendered in the hospital shall be clarified, as embodied in the resolutions adopted by the House of Delegates at this session, then such coverage would be included in medical coverage contracts.

I would like, if I may, to go over some of the items in this report and relate them to the Opinion Survey which was completed by this Society and presented on Monday. I think it is important to know whether, based upon this Survey, we are accomplishing the things demonstrated by the Survey.

The first is on page C-16-23-25-28 and deals with "All benefits will be on a service basis." I would like to ask Mr. Brenneman if he will give the figures in the Survey applicable to this point.

MR. BRENNEMAN: The question asked was, "Do you believe that Michigan Medical Service should be a service company or an indemnity company?" The total responses to that question were 2,487, or 100 per cent, with 41 per cent or 1,022 favoring a service company. An indemnity company was favored by only 15.7 per cent or 391. "No opinion," 43.2 per cent.

M. L. LICHTER, M.D.: Are there any other figures applicable to that?

MR. BRENNEMAN: There was another question immediately following that: "Do you believe Michigan Medical Service's medical service principle should be available only to low income groups (Under $5,000 income)?" The total responses at 100 per cent were 2,576: 83.1 per cent said "No"; 16.9 per cent said "Yes." In other words, very definitely they were opposed to limiting it to the under $5,000 income group.

M. L. LICHTER, M.D.: Under the services which are included, on page C-18, C-26 and C-18.

MR. BRENNEMAN: "Do you believe that benefits for medical consultations should be covered in Michigan Medical Service contracts?" The total response was 2,592. Those favoring it, saying "Yes," were 74.1 per cent. "No," 25 per cent.

Among the generalists versus the specialists, the generalists favored it by 67 per cent and the specialists by 77 per cent.

M. L. LICHTER, M.D.: And now the information in the Survey report concerning the deductible, A-25 and C-21.

MR. BRENNEMAN: I will give you the C-21 first. This is the Doctor Opinion Survey: "Should separate contracts be offered by Michigan Medical Service in addition to full pay policies, to permit the subscriber to buy co-insurance policy?" Total response, 2,410. "Yes," 82.2 per cent. "No," 17.8 per cent.

M. L. LICHTER, M.D.: Do you have the consumer attitude on that?

MR. BRENNEMAN: "In order to reduce the monthly cost of medical-surgical insurance, would you favor paying a deductible amount of the expense per each illness or disability?" The total answers were 1,000, because this was the Interview Survey. "Yes," 47 per cent. "No," 53 per cent. That was in the total mentioned. Then it was developed by the different types of plans due to membership income group, employer pays, and so on.

M. L. LICHTER, M.D.: The last thing deals with the income levels. That is at the bottom of pages C-16, C-22, C-23, C-24 and C-25.

MR. BRENNEMAN: The question was, "Do you believe Michigan Medical Service's principle should be available only to low income groups?" I have already read that one.

I think the next one is C-21 and C-22. "At present, participating doctors accept the Michigan Medical Service fee schedule as full payment for those subscribers under $5,000 income who hold such contracts. Because of present economic conditions, how do you believe this income limit should be changed?"

The total response was 2,443. The answers were as follows: "Raised with higher fee schedule," 1,456 or 59.6 per cent. "Remain unchanged," 773 or 31.6 per cent. "Raised with same fee schedule," 166 or 6.8 per cent. "Lowered with lower fee schedule," 48 or 2.0 per cent.

"Presupposing that appropriate fee schedules could be worked out, what would you recommend as income limits in the service contracts of Michigan Medical Service?"

Total responses were 2,312, making it 100 per cent. $2,500: 6.7 per cent. $5,000: 18.6 per cent. $7,500: 19 per cent. All three above 790 or 34.2 per cent. $10,000: 15 per cent. Others, 6.4 per cent.

"Would you favor placing the income limit in a new Michigan Medical Service contract at $7,500 if the present $5,000 income limit fee schedule were raised by 32 per cent?" The answers: "Yes," 68.1 per cent. "No," 31.9 per cent.

"Some persons, such as clerks in stores, farmers, part-time help, etc., earn less than $2,500 annually. Do you believe that the $2,500 income limit contract should be eliminated?" Answers: "No," 70 per cent. "Yes," 29.8 per cent.

"Do you believe the $2,500 income limit contract should be continued as an indemnity contract to serve as basic coverage for those with larger incomes?" Answers: "Yes," 44 per cent. "No," 55 per cent.

M. L. LICHTER, M.D.: Thank you, Mr. Brenneman. I didn't intend doing this to bore you; the intent rather was to demonstrate that the report just given you has met some of the wishes expressed by physicians and expressed by the consumer or patients, as developed in the Opinion Survey.

I feel that the Opinion Survey is a very valuable document which should be used very frequently, and

certainly as a guide in establishing medical benefits for the people of Michigan.

I move the adoption of this report as amended. [*Applause*]

C. W. OAKES, M.D.: I second the motion.

W. W. BABCOCK, M.D.: First I must apologize for not being at any of Dr. Lichter's Reference Committee meetings, because I had committed myself to others.

As I carefully listened to the report I had the impression that the Michigan State Medical Society is setting itself up as an approval agency for insurance carriers other than Blue Shield. If this is not so, I would like to know it. If it is so, then I want to know this: Have you had competent legal advice?

THE SPEAKER: The question has to do with the idea as to whether or not you secured legal opinion in relation to this portion of your report concerning itself with approval of other carriers than Blue Shield.

M. L. LICHTER, M.D.: First, I would like to state that this proposal does contemplate endorsing plans of insurance carriers other than Blue Shield under certain very strictly fine conditions. However, we are not endorsing a company. We are endorsing a plan which coincides with the principles that we have developed.

It is covered again in Section D, which in effect says that nobody is going to set the fee levels for doctors in Michigan but doctors in Michigan.

Does that answer your question, sir? Thank you.

[*The motion was put to a vote and was carried unanimously.*] [*Applause*]

PRESIDENT WALLS: Mr. Speaker, I would like to ask for the privilege of the floor.

As your President for ten more hours, I would like to take this opportunity to express my personal appreciation and that of the State Medical Society for the tremendous job that this Reference Committee and everyone concerned has done in helping to bring this to such a fine conclusion.

This is very touching for me because it is one of the best highlights of my year's work. They have brought it to a splendid conclusion. I am sure there will be a lot more wrinkles to be ironed out, but I certainly appreciate the tremendous amount of work that has been done on this particular project. Thank you very much. [*Applause*]

W. W. BABCOCK, M.D.: I would like to add to Dr. Walls' remarks to this extent: I feel that history has been made at this session, and I would like to see the pictures of the Reference Committee and a human interest story published for the membership of MSMS in THE JOURNAL. [*Applause*]

G. W. SLAGLE, M.D.: Mr. Speaker, may I ask for the privilege of the floor?

This House is to be commended on its action. In monumental things of this type unfortunately sometimes it becomes misnamed, such as calling this the "Slagle report." I want to assure you that the report of the Committee was the result of many, many minds. Many more people beside our good friends on the Committee worked on this. We sought advice from all sources. Credit should go to everyone, and I am sure it does.

I want to thank the Reference Committee for the dispatch with which they have handled the situation. Everyone had a chance to express opinions. The Reference Committee has done a Herculean task, and I believe the results will be tremendous. It is truly an epochal thing, and I want to thank the Society and this House of Delegates for approving it the way they have. Thank you very much. [*Applause*].

THE SPEAKER: We have one more item of business that must be disposed of.

XVI—11(1). MSMS ADVISORY COMMITTEE TO MMS

M. L. LICHTER, M.D.: Mr. Speaker, we have one more resolution. I shall not read the original resolution.

The Reference Committee offers a substitute resolution No. 36 as follows:

"Whereas, a vast amount of information and knowledge on prepaid medical care has been acquired by various committees of MSMS and the Opinion Survey, and

"Whereas, this information will influence the extent of coverage to be offered, and

"Whereas, the members of this House of Delegates will not have had sufficient time during this session to digest the information gathered; therefore, be it

"RESOLVED: That all information on prepaid medical care collected by said committees and Survey be transmitted to the Board of Directors of Michigan Medical Service, urging the development and offering of contracts which will include desired medical care benefits as indicated by the information obtained in these studies; and be it further

"RESOLVED: That the Committee on Michigan Medical Service of the Michigan State Medical Society be utilized in an advisory capacity to Michigan Medical Service to implement this resolution."

The action of the House today has made this unnecessary.

I move, by authority of the Reference Committee, that **no action** be taken on this resolution.

R. W. TEED, M.D.: I support the motion.

[*The motion was put to a vote and was carried unanimously.*]

M. L. LICHTER, M.D.: I move the approval of the report of the Reference Committee on Medical Service and Prepayment Insurance as a whole, as amended.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

XVIII. ADJOURNMENT

THE SPEAKER: Gentlemen, I cannot tell you how grateful I am (and I am sure I speak for the Vice Speaker also) for the very business-like way in which you have conducted this entire session. I have never heard a session composed of men who are professional individualists, who have settled down and have let personalities go by the wayside, and who have tackled the business at hand and worked it out as well as you have done. I thank each and every one of you.

This session of the 92nd annual meeting of the House of Delegates of the Michigan State Medical Society is now declared adjourned.

[*The meeting adjourned sine die at 10:15 a.m.*]

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

DEPARTMENT POLICY IN TUBERCULOSIS CASEFINDING

Within recent months, there have been several reports in the press and on radio and television which have raised some questions regarding possible health hazards associated with community-wide mass x-ray programs for the detection of previously unsuspected tuberculosis and other chest diseases. These reports have apparently caused apprehension among certain people as to the safety of such procedures. A brief review of the pertinent facts may help to clarify this situation.

Beginning in June, 1956, the National Academy of Sciences, National Research Council issued a series of reports dealing with the effects of x-radiation on the human body. These reports on the effects of x-radiation stimulated a great deal of discussion and caused all concerned with the problem to reconsider and re-evaluate programs based upon the use of x-radiation in all its forms.

Briefly, these reports served to point up the well known fact that the effect of ionizing radiation on living tissue is to injure or destroy cells. Even the therapeutic use of x-rays is based on the ability of radiation to injure or destroy unwanted cells, such as malignant cells. Furthermore, the ability of radiation to injure is cumulative; each exposure to radiation adds to the over-all destructive effect. Thus, it seems reasonable to regard all exposure as a loss to health unless the benefit warrants the risk.

The impact of these reports on those engaged in mass chest x-ray programs was, perhaps, especially notable, since the screening x-ray examination of the lungs has been for many years one of the most important and dependable tools of the public health worker in early diagnosis of tuberculosis which, despite tremendous developments in treatment, remains a major public health problem. Health agencies are charged with the responsibility of protecting health. This clearly involves protecting the public against unnecessary exposure to x-radiation. It also involves protecting the public against unnecessary exposure to persons with active tuberculosis. The choice of action, then, must be determined by weighing the benefits to be derived from x-ray screening procedures against the liability of harmful effects from radiation.

The policy of the Michigan Department of Health is, as always, to protect all persons against unnecessary exposure. The screening x-ray, accordingly, is used only on a restricted basis and only when maximum safeguards are observed. The risks involved in such screening programs conducted under the auspices of the state and local health departments are insignificant when compared to the great benefits to be derived.

The Michigan Department of Health will therefore continue, as it has for several years, to restrict the use of the chest x-ray screening technique to adults in relatively high tuberuclosis incidence areas or groups. These include population segments where the incidence of tuberculosis is high, occupational groups where there are greater risks; age groups where the incidence is high; i.e., men over forty-five and young and middle aged women. In addition, the Michigan Department of Health encourages casefinding in schools and in those areas with low or average incidence by means of the tuberculin test, followed by x-raying of reactors, and contact tracing. Along with this, the health department continues to encourage the use of general hospital admission x-rays, because these provide a much higher yield of new cases of tuberculosis than x-rays of the general population.

In summary, these are the principles that guide the policy of the Michigan Department of Health, as it bears upon tuberculosis casefinding activities:

1. The chest x-ray survey is a basic part of the program for early detection of tuberculosis and non-tuberculous chest diseases. It has been proven to be most effective when the population groups surveyed have been selected on a basis of th prevalence of disease. If these principles of survey operation are observed, the benefits to be derived far out-weigh the potential risks of radiation. Failure to take prevalence into consideration not only results in a low return in terms of new cases found, but also exposes persons to unnecessary radiation.

2. Since tuberculosis is relatively infrequent in persons under the age of eighteen years, it is recommended that this age-group be screened by means of the tuberculin test and only the reactors examined by x-ray. Experience has shown that tuberculin testing is an effective method of screening school children.

3. Periodic checks of the operating x-ray survey equipment should be made to assure protection from unnecessary radiation.

4. Continuing evaluation of mass x-ray surveying as a tuberculosis casefinding method will be made by the Michigan Department of Health.

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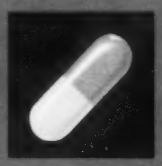

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In Memoriam

John J. Blue, M.D., sixty-six, Cedarville physician and surgeon, died October 23, 1957. Doctor Blue was born in Columbiaville, Michigan, was a graduate of the Detroit College of Medicine in 1917 and served four years in the Navy as a surgeon. Doctor Blue practiced medicine at Chesaning and Owosso, Michigan, and in Fostoria, Ohio, before starting his practice in Cedarville in 1949. Doctor Blue moved to Cedarville in the Upper Peninsula with the thought of retiring, but he resumed practice to fill a community need.

Herbert L. Goodman, M.D., thirty-eight, Detroit physician, collapsed and died of a heart attack while in his office on the afternoon of November 15, 1957. Doctor Goodman was medical director of Wayne County General Hospital and was Assistant Professor of Clinical Medicine at Wayne State University College of Medicine. A graduate of Wayne in 1945, he specialized in hematology and cardiology.

From 1945 until 1955, Doctor Goodman was on the staff of Wayne Medical College and Receiving Hospital. After serving two years with the Army Medical Corps, he was appointed director of Wayne County General hospital in June, 1947.

He was a member of Phi Lambda Kappa and Alpha Omega Alpha, medical fraternities.

John J. Kingma, M.D., fifty-six, Grand Rapids psychiatrist, died October 26, 1957. Doctor Kingma was born in the Netherlands, came to this country at the age of nine, and after living a few years in New Jersey moved to Grand Rapids.

He was a graduate of Calvin College and University of Michigan medical schools. After conducting a medical practice in Decatur for nine years, he took a psychiatric residency in New York City and then joined the staff of the Christian Sanatorium at Wyckoff, New Jersey, where he served for thirteen years before returning to Grand Rapids.

Heinrich Guenther Kobrak, M.D., fifty-two, Detroit physician, died October 9, 1957. He was born in Berlin, Germany, and graduated from the University of Munich, Germany, in 1928. He interned at the Rudolf Virchow Hospital in Berlin in 1929 and did postgraduate work at the University of Basel, Switzerland, in 1929-30 and at the University of Heidelberg in 1931. He then came to the United States and entered the department of physiology at the University of Chicago. He received his Ph.D. degree in Physiology in 1937. After that, he became a fellow and research assistant in the Otolaryngology Division of the Department of Surgery at the University of Chicago and received his M.D. degree there. In 1946, he was made assistant professor and, in 1948, associate professor in that field, all at the University of Chicago.

In 1954, he came to Wayne State University College of Medicine and became Professor of Otology, continuing his research in that field. He wrote many scientific papers relative to hearing mechanisms and to objective hearing tests. The final chapters of his book, "The Middle Ear," had just reached the publisher (University of Chicago Press) before his death.

Doctor Kobrak was much in demand as a professional speaker. Like many European-born scientists, he was an excellent musician and was himself accomplished on the viola.

Charles R. Murray, M.D., fifty-two, Saginaw physician, was killed November 17, 1957, in an automobile accident on route M-18 while returning to Saginaw from a hunting trip.

Doctor Murray was a graduate of Wayne State University Medical College. He interned at Detroit Receiving Hospital and at the time of his death was chief of staff at St. Mary's Hospital.

John M. Salowich, M.D., fifty-six, Detroit physician, died November 13, 1957, while vacationing in Hermosa Springs, Florida.

Doctor Salowich was medical director for ten years at the Chrysler Corporation's DeSoto plant.

Born in Wilkes-Barre, Pennsylvania, Dr. Salowich lived in Detroit for fifty years, having graduated in 1931 from the Detroit College of Medicine. A Mason, he was a member of St. Nicholas Lodge, the Scottish Rite, Moslem Shrine and the Chanters.

Communication

To the Editor

Dear Sir: In the September number of THE JOURNAL of the Michigan State Society, page 1159, "Function of an Amputee Clinic," under the heading, Physical Therapy, "ultraviolet light" is mentioned.

The visible spectrum of sunlight is now modernly supposed to consist of three primary colors; violet, green, and red.

At each end of the visible or light spectrum, respectively, are the invisible rays of the ultraviolet and the equally invisible rays of infrared.

It is a curious fact that many physical therapy (medicine) authorities consistently mistakenly continue to mention ultraviolet *light* synonymously with rays. As both are invisible and equally non-visual rays, why should either end be termed light and the other never so illogically?

In "Electrotherapy and Light Therapy," page 403 (1935), Richard Kovacs, thus conclusively writes: "Light is a form of radiant energy which makes objects visible by stimulating the retina of the eye. Ultraviolet and infrared radiation do not render objects visible."

Yours in the interest of correct, scientific physical therapy,

JOSEPH E. G. WADDINGTON, M.D.

Detroit, Michigan
November 7, 1957

. . . . . NEWS MEDICAL

MICHIGAN AUTHORS

Ignace J. Robarge, M.D., and **Lee Carrick, M.D.,** Detroit, are the authors of an article entitled "The Treatment of Dermatoses of Psychogenic Origin with Bellergal," published in *Antibiotic Medicine and Clinical Therapy,* July, 1957.

L. Douglas MacRae, M.D., and **D. Evangeline MacRae, M.T. (A.S.C.P.)** Bay City, are the authors of an article entitled "The Long-Term Regulation of Dicumarol Dosage by the Venous Clotting Time," published in the *American Practitioner and Digest of Treatment,* November, 1957.

Joseph E. Kincais, M.D., Ann Arbor, is the author of an article entitled "Military Medicine during the Civil War," published in the *University of Michigan Medical Bulletin,* August, 1957.

Charles G. Johnston, M.D., and **Fumio Nakayama, M.D.,** Detroit, are the authors of an article entitled "Solubility of the Cholesterol and Gallstones in Metabolic Material," read at the 14th Annual Meeting of the Central Surgical Association, Chicago, February, 1957, and published in the AMA *Archives of Surgery,* September, 1957.

Edwin M. Knights, Jr., M.D., and **Victor Jablokow, M.D.,** Detroit, are the authors of an article entitled "A One-Drop Method for Detection of Albuminuria," published in *The Journal of the American Medical Association,* November 9, 1957.

Daniel W. Johnston, M.D., William B. Jensen, M.D., and **Mary Lou Byrd, M.D.,** Grand Rapids, are the authors of an article entitled "Successful Cardiac Resuscitation following Tetracaine Reaction," published in the AMA *Archives of Otolaryngology,* November, 1957.

John W. Henderson, M.D., Ann Arbor, is the author of an article entitled "Progressive Exophthalmos in Thyroid Disease," published in THE JOURNAL of the Michigan State Medical Society, July, 1957, and digested in the *Digest of Ophthalmology and Otolaryngology,* July, 1957.

M. Koike, M.D., and **S. Lutz, M.D.,** Detroit, are the authors of an article entitled "Recurrent Ileal Prolapse and Incarceration in an Ileocecal Bladder—Case Report," published in *Harper Hospital Bulletin,* September-October, 1957.

W. O. Umiker, M.D., L. Weatherbee, B.S., R. Rapp, M.D., and **D. E. Boblitt, M.D.,** are the authors of an article entitled "Cytologic Effects of Irradiation in Oral Smears: A Study of the Changes in Benign Squamous Cells," published in the *University of Michigan Medical Bulletin,* August, 1957.

Michael N. Zelenock, M.D., Robert D. Larsen, M.D., and **Joseph L. Posch, M.D.,** Detroit, are the authors of an article entitled "Treatment of Fractures of the Hand," read at the 14th Annual Meeting of the Central Surgical Association in Chicago, February, 1957, and published in AMA *Archives of Surgery,* September, 1957.

Jack Kevorkian, M.D., Ann Arbor, is the author of an article entitled "Incidence of Carcinoid Tumors: Review of Necropsy and Surgical Specimens at the University of Michigan," published in the *University of Michigan Medical Bulletin,* August, 1957.

Marion S. DeWeese, M.D., Melvin M. Figley, M.D., William J. Fry, M.D., Robert Rapp, M.D., and **Howard L. Smith, M.D.,** Ann Arbor, are the authors of an article entitled "Clinical Appraisal of Percutaneous Splenoportography," read at the 14th Annual Meeting of the Central Surgical Association, Chicago, February, 1957, and published in the AMA *Archives of Surgery,* September, 1957.

Wilma Donahue and **Clark Tibbitts** are the authors of a book entitled "The New Frontiers of Aging," published by the University of Michiagn Press, Ann Arbor.

W. L. Anderson, M.D., and **G. C. Thosteson, M.D.,** Detroit, are the authors of an article entitled "Excerpts —1957 Meeting, American Diabetes Association," published in the *Harper Hospital Bulletin,* September-October, 1957.

Samuel J. Nichamin, M.D., and **William S. Gonne, M.D.,** Detroit, are the authors of an article entitled "Foreign Body (Paper Clip) in the Esophagus of a Young Infant," published in the *Journal of Pediatrics,* August, 1957.

Richard S. Johnson, M.D., Detroit, is the author of an article entitled "Sarcoma of the Uterus," published in *Harper Hospital Bulletin,* September-October, 1957.

Harry C. Saltzstein, M.D., Detroit, is the author of an article entitled "Present-day Problems in Intern-Resident Education," published in the *Harper Hospital Bulletin,* September-October, 1957.

William C. Grabb, M.D., Ann Arbor, is the author of an article entitled "Pilonidal Disease: Series of 100 Consecutive Cases," published in the *University of Michigan Medical Bulletin,* August, 1957.

H. O. Wagg, M.D., C.M., Detroit, is the author of an article entitled "Cerebrovascular Accidents in Pregnancy," published in the *Harper Hospital Bulletin,* September-October, 1957.

J. R. Caldwell, M.D., Detroit, is the author of a paper entitled "Hydralazine Syndrome-Hypersensitivity or Toxicity"? which appeared under "Clinical Notes" in J.A.M.A. of December 7, 1957.

* * *

The Board of Regents of the American College of Physicians at the last annual meeting, November 9-10, 1957, in Philadelphia, accepted the following members into full fellowship: Matthew R. Kinde, M.D., Battle Creek; Clayton K. Stroup, M.D., Flint; Robert W. Talley, M.D., Kalamazoo; and Richard C. Bates, M.D., Lansing.

Also named as Associates of the College were: Norman J. Goode, Jr., M.D., Ferndale; Joseph Thaddeus Sadilkowski, M.D., Garden City; Raymond H. Murray, M.D., Grand Rapids; Jerome Francis Cordes, M.D., Lansing; Fred W. Whitehouse, M.D., St. Clair Shores; Robert Kenneth Noxon, Jr., M.D., Birmingham; and from Detroit, John Burton Bryan, M.D.; Herbert C. Cantor, M.D.; Laurie C. Dickson, M.D.; Boy Frame, M.D.; Edwin M. Knights, Jr.; and Milton J. Steinhardt, M.D.

These new members will have ten years in which to complete their preparation for full fellowship.

* * *

Nicholas S. Gimbel, M.D., Detroit, Associate Professor of Surgery, Wayne State University College of Medicine, was elected to membership in the Western Surgical Association at the annual meeting in Salt Lake City.

Two Detroit physicians were honored by the Radiological Society of North America at its 43rd annual session in Chicago, for prize-winning scientific exhibits which received *summa cum laude* honors. Illustrated are James E. Lofstrom, M.D., and Morris Tatelman, M.D., receiving the honors. Four other Detroit physicians, J. E. Webster, M.D., J. L. Chason, M.D., J. S. Meyer, M.D., and E. S. Gurdjian, M.D., were included in the honor.

* * *

The American Orthopsychiatric Association will hold its thirty-fifth annual meeting at the Commodore and Roosevelt Hotels in New York City, March 6, 7 and 8, 1958.

The American Academy of General Practice, with more than 8,000 members, announces its Tenth Anniversary Assembly on Tuesday, March 25, 1958, in combination with the Dallas Southern Clinical Society. The Congress of Delegates will meet at 2 p.m. on Saturday, March 22. On Wednesday evening, March 26, a final reception and dance, honoring the new President of the Academy, Malcomb E. Pheleps, M.D., of Elrino, Oklahoma, will be held.

* * *

Treatment with isoniazid can prevent 80 per cent of the complications of primary tuberculosis in young children, the first report of a U. S. Public Health Service study indicates.

Involved in the study were 2,750 children with asymptomatic primary tuberculosis. Half were given isoniazid pills daily. The other half received placebos. During the first year, five children receiving isoniazid and twenty-six on placebos developed serious extrapulmonary complications. The study is being conducted by thirty-three pediatric centers including Herman Kiefer Hospital in Detroit. The report is published in the December issue of the *American Review of Tuberculosis and Pulmonary Diseases.*—MICHIGAN TUBERCULOSIS ASSOCIATION.

* * *

The Sixth Annual Symposium on Trauma was held in Detroit on December 4, 1957, under the sponsorship of Wayne State University College of Medicine and the Michigan Committee on Trauma of the American College of Surgeons at Detroit Receiving Hospital. There were ward walks, four operating room demonstrations: tendon repair, "repair of facial injury," surgery of burns, open reduction of fracture, by members of the faculty. A luncheon was served at noon at the Wayne State University Medical School cafeteria. In the afternoon, at the clinical laboratory the following subjects were presented: abdominal trauma in the adult, abdominal trauma in the child, management of the patient with crushed chest, question and later substitute intestinal segments in abdominal trauma by John Hammer, M.D., of Kalamazoo; foreign bodies in the eye, then a panel on fracture problems discussing value of traction in present-day treatment of fracture, dangers of infection in 1950, also followed by a question period.

* * *

Max K. Newman, M.D., Detroit, presented a program entitled "Institutional Geriatrics at the Jewish Home for the Aged," November 17, 1957. He also gave a talk entitled "Myasthenia Gravis, Its Neuromuscular Diagnosis and Management" before the Michigan Chapter of the Myasthenia Gravis Foundation at the Barlum Hotel, in Detroit, on November 17, 1957. On November 19, 1957, he gave a talk on "Chronic Disability and Chronic Disease. The Utilization of the Facilities of a General Hospital in Their Control," at the Michigan Welfare Conference. At that time he

was elected to the Board of Directors of the Michigan Welfare League. On November 21, he talked to the League of Jewish Women's Organizations on "Clinical Problems and Management of Muscular Dystrophy" in Detroit.

* * *

The Medical Society of the State of Wisconsin conducted a clinical teaching program, November 5, 6 and 7, 1957, in Monroe at the Country Club, in Viroqua at the Vernon County Hospital, and in Chippewa Falls at the Hotel Northern. It was an afternoon program with Robert C. Parkin, M.D., Director of Postgraduate Medical Education at the University of Wisconsin Medical School as moderator. There were four topics of discussion: "Rehabilitation of the Cardiac" by Elston Belknap, M.D., Marquette University School of Medicine; "Eye Care in General Practice," Frederick J. Davis, M.D., University of Wisconsin Medical School; "Diabetes in Pregnancy," Russel J. Paalman, M.D., Grand Rapids, Michigan; and "Bleeding as a Symptom in Infancy and Childhood," Nathan J. Smith, M.D., University of Wisconsin Medical School. The dinners were followed by general symposium and question and answer periods.

* * *

The Smith Kline & French Laboratories established its Foundation as an independent philanthropic arm to promote basic research in medicine and related sciences. On November 28, 1957, the Foundation made its first report of the first four years from 1953 through 1956 and the disbursement of $1,457,876.00, listing the grants covering the whole United States. This report is the first public announcement.

Five areas are supported with SKF Foundation funds. Basic research in medicine and related sciences received the largest portion of funds—$673,910 for projects unrelated to the Philadelphia pharmaceutical firm's commercial research interests. Next in order were education grants, $320,711; public charities and community improvement, $178,650; mental health, $157,500, and building and equipment funds, $127,105.

Fifty-four national organizations received grants to the total of $295,250. These included many organizations—Red Cross, Muscular Dystrophy, Polio, several psychiatric societies and last on the list was World Medical Association, with a total of $7,500 in four grants. The grants for each state were listed. In Michigan, there was a Henry Ford Hospital grant for laboratory equipment $3,000 in the Department of Dermatology, and the University of Michigan had a grant of $7,500 to the Department of Zoology to conduct basic studies in microbiological genetics.

* * *

The Council on Medical Defense of the American Medical Association, together with the Association of Medical Colleges, has set up a program, Medical Education for National Defense (MEND), to encourage the teaching in medical schools of medical defense, military medicine and disaster medicine. The program started in 1952 with five pilot schools and has steadily ex-

panded until now there are forty-five schools with 14,000 medical students involved. The cost of the program has been $10,000 per school per year, or about $30 per student. Last year, the total program including the Washington co-ordinators office, was $325,000, but it is feared that the economy wave now upon us may restrict this program. Medical schools are more or less self contained in setting up their program, but MEND sponsors a series of symposiums at federal medical installations, also conducts a tour for deans and coordinators of MEND—affiliated schools, designed to introduce them to current problems and trends in the federal services.

The Council is also considering the probability of fall-out debris deposition.

* * *

The Eighth County Medical Societies Civil Defense Conference was held in Chicago in November. E. G. Sharp, M.D., of Philadelphia, was selected as conference chairman, and Paul S. Parrino, M.D., of Battle Creek, was named program chairman for the next annual conference, November 8-9, 1958, at the Morrison Hotel in Chicago.

* * *

The Atomic Energy Commission is considering a long-range research program on all phases of atomic radiation to increase the exact radiation effects and to form increased emphasis on the genetic changes which might occur in the human being. The aid of the medical profession in general is needed, and very especially the medical men prepared to serve in disaster condition or military emergency.

* * *

Appointment of Anthony C. Nolkes, M.D., Detroit, as Assistant Dean in Wayne State University College of Medicine and Director of Medical Education at Children's Hospital was announced in November.

Dr. Nolke will represent both the Dean of the College of Medicine, Dr. Gordon H. Scott, and the Hospital in developing and coordinating their joint medical education program. He will continue as Associate Chief of Pediatrics at Children's Hospital.

Dr. Nolke graduated from Indiana University Medical School in 1942. During World War II, he was a captain in the medical corps attached to the infantry. He came to Detroit for residency training at Herman Kiefer and Children's Hospital in 1947. He has been a staff member of the College of Medicine since 1948 and associate professor in pediatrics since 1953.

A long-time working relationship between the University and Children's Hospital was officially cemented by an affiliation agreement approved by both institutions several weeks ago. The medical education at Children's includes teaching eighty Wayne State University medical students and working with a full quota of forty-two doctors in their pediatrics residency training. The College of Medicine-Children's Hospital staff members also carry on research and patient services in medicine, surgery, x-ray, pathology and hematology.

(Continued on Page 150)

(Continued from Page 148)

The Health Information Foundation announced November 1, 1957 that in 1958 it will sponsor and jointly conduct with the National Opinion Research Center of the University of Chicago another nation-wide survey of medical costs and voluntary health insurance coverage. The new study will be a resurvey of the HIF-NORC study of 1953 which provided basic health insurance data.

A grant of $167,000 was approved for the new study at a recent meeting of the Foundation's Executive Committee. The Committee acted in behalf of the more than 200 companies in the drug, pharmaceutical, chemical and allied industries that sponsor the Foundation.

According to George Bugbee, Foundation President, the 1958 survey will undoubtedly show the great improvement in voluntary health insurance coverage since 1953. He says:

"That improvement has been considerable. Since 1953, enrollment in voluntary health insurance has increased from 58 per cent of the American population to more than 70 per cent.

"More significantly, the total percentage of private payments for medical care covered by Blue Cross-Blue Shield, insurance companies and other types of plans has doubled during the same period. The Foundation believes that its 1953 study, which documented the strengths and weaknesses of voluntary health insurance for the first time on a nationwide basis assisted in stimulating this tremendous growth."

The 1958 study, Bugbee explained, will provide comparisons with the 1953 data of medical expenditures, utilization of medical services and patterns of health insurance coverage. In addition, it will collect a larger body of data on individuals not presently protected by health insurance and on families with high costs.

A detailed report of the Foundation's earlier survey was published by the McGraw-Hill Book Company in 1956 as "Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey." It was compiled and written by Odin W. Anderson, Ph.D., Foundation Research Director, and Jacob J. Feldman of the staff of the National Opinion Research Center.

* * *

Smallpox infection was carried by international travelers into eighteen countries last year and as a result, eight of them suffered epidemics of this quarantinable disease. At the annual meeting of the World Health Organization in Geneva, warnings were issued against a relaxation of vaccination measures against smallpox. They drew attention to the advantages of dried smallpox vaccine for mass campaign. The dried vaccine is easily transferable, remains effective without refrigeration, and does not spoil even in the tropics. The eight countries where smallpox epidemics developed were Ceylon, Ghana, Iran, Italy, Lebanon, Sierra Leone, Sudan and United Kingdom. Smallpox was imported without developing epidemic proportions into Argentina, Federal Republic of Germany, Greece, India, Iraq. Jordan, Netherlands, Paraguay, Syria and Uruguay.

(Continued on Page 152)

(Continued from Page 150)

The Educational Council for Foreign Medical Graduates, after nearly three years of planning, has opened offices in Evanston, Illinois. Some form for evaluations of services has become necessary, and the American Medical Association, Association of Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards of the United States have established an independent agency which will be sponsored by these four agencies and financed by the Kellogg Foundation and the Rockefeller Foundation. It will be run by a ten-member board, two from each of the sponsor organizations, one representing the public at large and one named by the United States Department of Defense, the other by the Department of Health, Education and Welfare. The Council will make available to properly qualified foreign medical graduates while still in their own country all information on how to obtain certification. This involves a three-way screening process. First, the Council will certify that the student's educational qualifications have been checked and found meeting minimal standards. Second, the Council will certify to enough knowledge of English for the needs of an internship in an American hospital. Third, the Council will certify to the general knowledge of medicine as evidenced by passing American medical qualifications examination. The Council will provide hospitals, state licensing boards and specialty boards which the foreign medical graduates designate, with the results of the three way screening.

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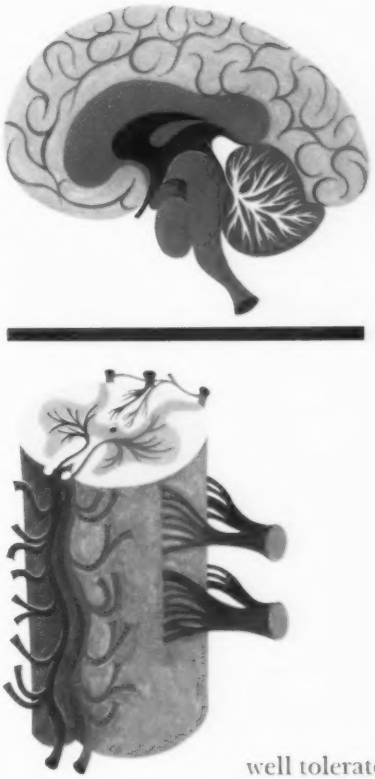

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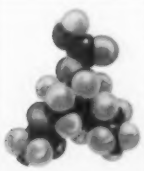

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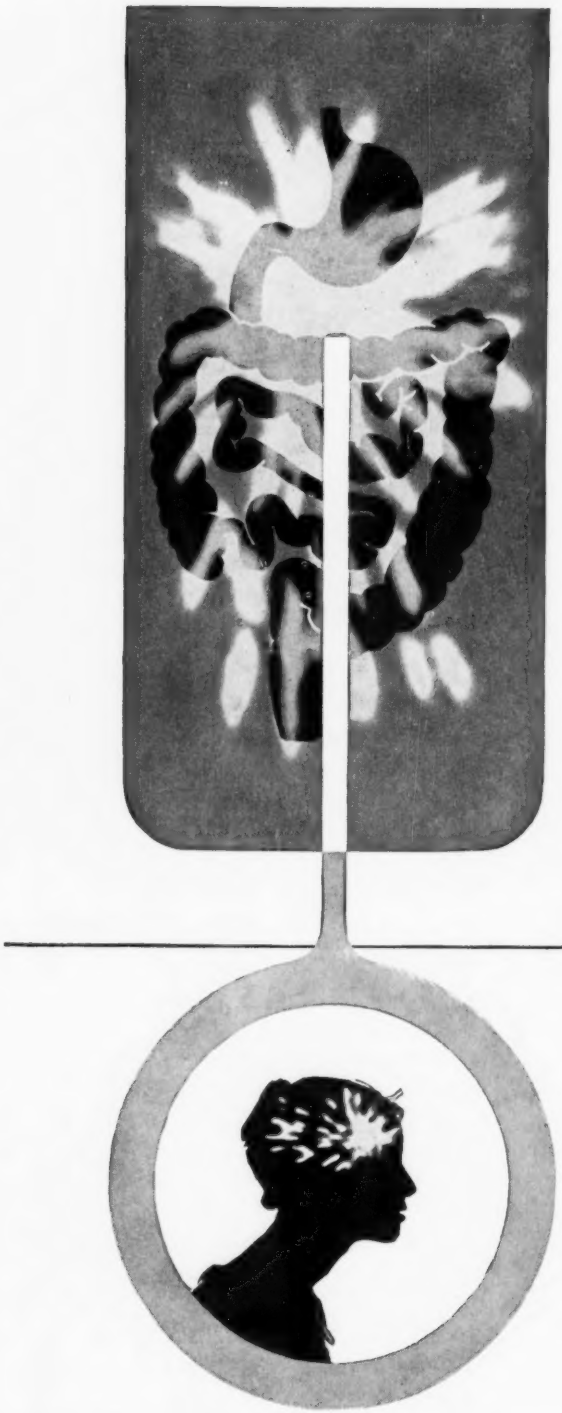

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